INDIANA HEALTH COVERAGE PROGRAMS

Systems Documentation - Surveillance Utilization Review

LIBRARY REFERENCE NUMBER: SU10003
REVISION DATE: NOVEMBER 2003
VERSION 3.0

Library Reference Number: SU10003

Document Management System Reference: Systems Documentation – SUR

Address any comments concerning the contents of this manual to:

EDS Systems Unit
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204
Fax: (317) 488-5169

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	2000	Multiple	New Format	Alicia Molby
Version 2.0	November 2002	All	Updates for double-sided printing and CSR #IN012514	Karen Girgis
Version 3.0	November 2003	Multiple	HIPAA updates, converted fonts and margins to be in accordance with style guide, changed name throughout to *Systems Documentation* from *Users Guide.*	HIPAA Publications

Table of Contents

Section 1: SUR Main Menu Window

Introduction

The *SUR Main Menu* window displays nine buttons associated with each of the SUR Control Files used to maintain and generate the SURS reports.

The Option List (10 file) button accesses the SURS report control options, which include: reports to be produced, date ranges, reporting minimums, sort criteria, and many other options.

The Cross Reference (20 file) button accesses the SURS report peer grouping criteria and cross referencing.

The Selected Provider (30 file) button accesses the request of "selected" provider treatment analysis and profile reporting.

The Summary Profile (40 file) button accesses the summary profile maintenance functions.

The LTC Select Providers (50 file) button accesses the selection and request of long term care provider reporting.

The Selected Member (60 file) button accesses the request of selected member profile reporting.

The Provider Deselect (70 file) button accesses the deselection of providers from exception processing.

The Recipient Deselect (70 file) button accesses the deselection of members from exception processing.

The Provider History/Sample button accesses the provider history and random sample request functions.

The Recipient History/Sample button accesses the recipient history and random sample request functions.

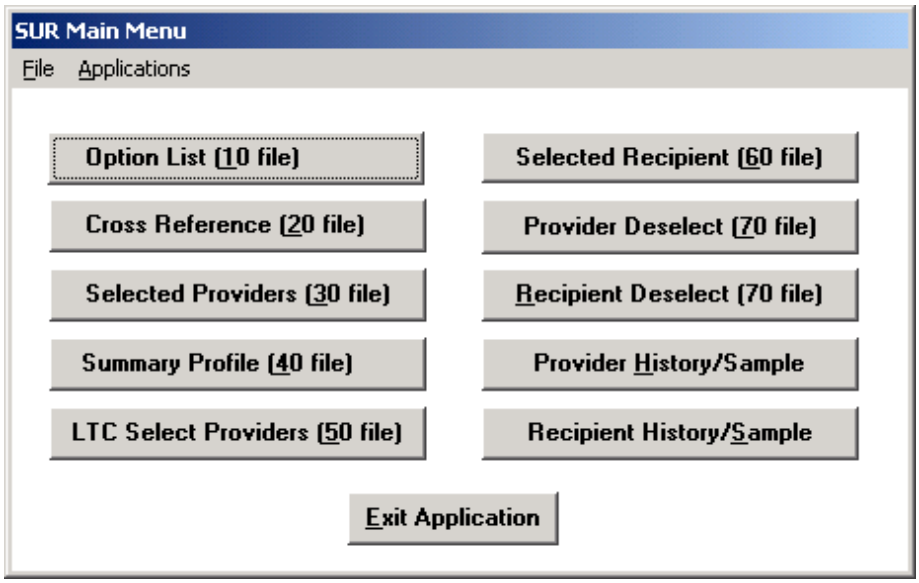


Figure 1.1 – SUR Main Menu Window

Section 2: Option List Window

Introduction

The Cycle Control Data and Customer Options Control file is reviewed prior to each quarterly cycle to determine the reports to produce, date ranges, date types, reporting minimums, and so forth.

The *Option List* window accesses the following functions:

- Updates Utilization Review cycle's option selections
- Views Utilization Review cycle's option selections

The *Option List* window is accessed by clicking **Option List (10 file)** on the SUR Main Menu, or by pressing **Alt** plus **1** on the keyboard.

Refer to the *SURS User's Guide* for a detailed description of valid element values and consequential effects on the SURS data.

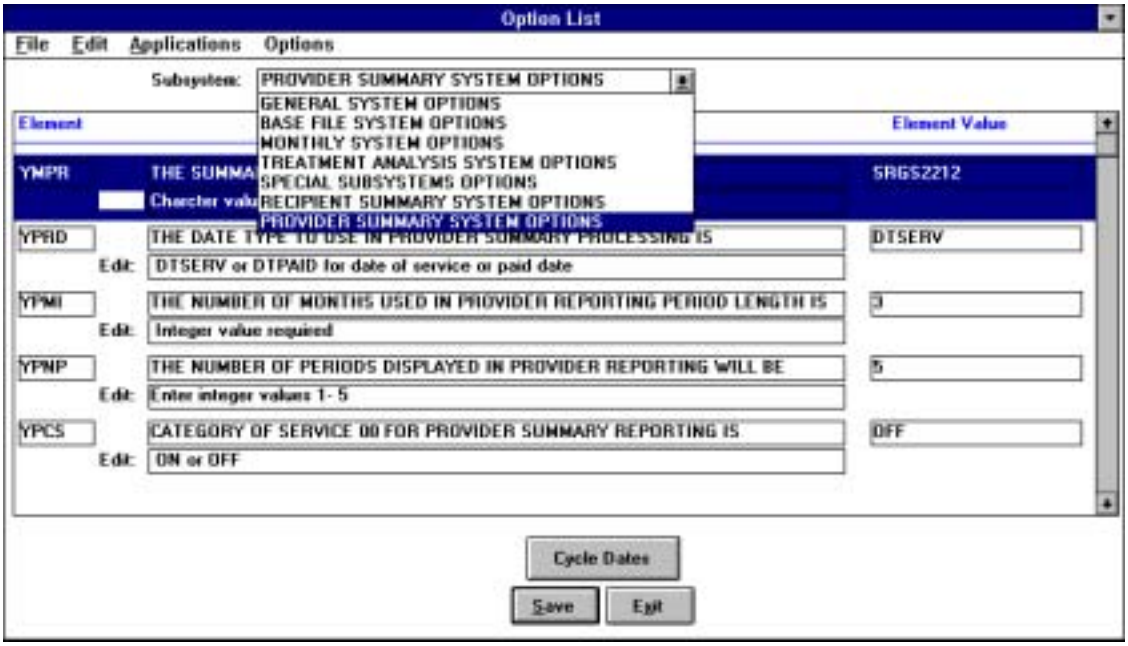


Figure 2.1 – Option List Window

File	Applications	Options
Save	Option List (10 File)	Cycle Dates
Print	Cross Reference (20 File)	
Exit	Selected Providers (30 File)	
Exit Indiana*AIM*	Summary Profile (40 File)	
	LTC Select Providers (50 File)	
	Selected Member (60 File)	
	Provider Deselect (70 File)	
	Member Deselect (70 File)	
	Provider History/Sample	
	Recipient History/Sample	

Figure 2.2 – Option List Window Menu Tree

This is the menu bar for the *Option List* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

Save – Saves changes made to the window.

Print – Print a data window, current window or the entire screen.

Exit – Returns to the previous window.

*Exit Indiana*AIM – Exits Indiana*AIM*.

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers.

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members.

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function.

Recipient History/Sample – Click to access the SURS Recipient History/Sample Request function.

Menu Selection: Options

This menu accesses all the windows that relate to the control file.

Cycle Dates – Accesses the *SUR Option Dates* window

Field Information

Field Name: Subsystem

Description – The SUR reporting subsystem applies to the listed options.

Format – General System Options

Base File System Options

Monthly System Options

Treatment Analysis System Options

Special Subsystem Options

Member Summary System Options

Provider Summary System Options

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: Element

Description – The option's element code.

Format – Alphanumeric

Features – Display only

Edit – None

To Correct – n/a

Field Name: Element Description

Description – Description of the preceding element code.

Format – Alphanumeric.

Features – Display only

Edit – None

To Correct – n/a

Field Name: Element Value

Description – Value indicating the option selected for the element.

Format – Alphanumeric.

Features – None

Edit – Refer to the SURS User's Guide.

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_OPTIONS

Menu – M_SUR_OPTIONS

Data Windows – DW_SUBSYSTEM

DW_SUR_OPTIONS

System Features

Click **Cycle Dates** and the Cycle Dates option on the Options menu bar provide access to the *Option Dates* Window.

Click **Save** and changes to the window are saved and the user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Exit** to return to the SUR Main Menu.

Section 3: SUR OPTION DATES Window

Introduction

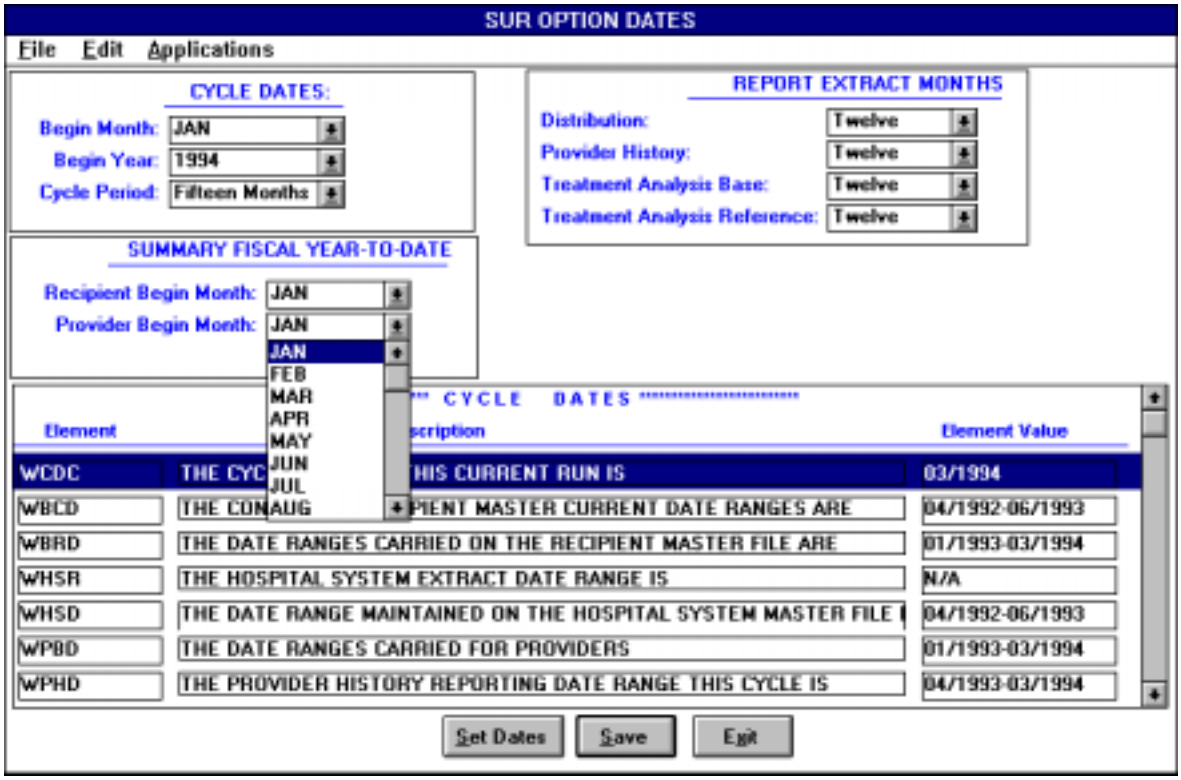
The Cycle Control Data and Customer Options Control file is reviewed prior to each quarterly cycle to determine the reports to produce, date ranges, date types, reporting minimums, and the like.

The *SUR OPTION DATES* window performs the following functions:

- Updates a Utilization Review cycle's date option selections
- Views a Utilization Review cycle's date option selections

The *SUR OPTION DATES* window is accessed by clicking **Cycle Dates** on the *SUR Options* window.

Figure 3.1 – SUR Option Dates Window



File	Applications
Set Dates	Option List (10 File)
Save	Cross Reference (20 File)
Print	Selected Providers (30 File)
Exit	Summary Profile (40 File)
Exit Indiana*AIM*	LTC Select Providers (50 File)
	Selected Member (60 File)
	Provider Deselect (70 File)
	Member Deselect (70 File)
	Provider History/Sample
	Recipient History/Sample

Figure 3.2 – SUR Option Dates Window Menu Tree

This is the menu bar for the *SUR OPTION DATES* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

Set Dates – Sets the new cycle dates

Save – Saves changes made to window

Print – Prints a data window, current window, or the entire screen

Exit – Returns to the previous window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers.

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members.

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function.

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Field Information

Field Name: CYCLE DATES: Begin Month

Description – Month that the cycle will begin.

Format – Three alphabetic characters. For example, *JAN* for January or *FEB* for February and so forth

Features – Drop-down box

Edit – Please select CYCLE DATE.

To Correct – Select a cycle begin month from the drop-down box

Field Name: CYCLE DATES: Begin Year

Description – Year that the cycle begins

Format – Four numeric charaters (CCYY format)

Features – Drop-down box

Edit – Please select CYCLE DATE.

To Correct – Select a cycle begin year from the drop-down box

Field Name: CYCLE DATES: Cycle Period

Description – Number of months in the SURS cycle

Format – In increments of three. For example, three, six, nine, 12, 15, and so forth.

Features – Drop-down box

Edit – Please select CYCLE DATE

To Correct – Select a cycle period from the drop-down box

Field Name: REPORT EXTRACT MONTHS: Distribution

Description – Number of months to be extracted and added for the current quarter's reporting of distribution report data

Format – In increments of three. For example, three, six, nine, 12, 15, and so forth.

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: REPORT EXTRACT MONTHS: Provider History

Description – Number of months to be extracted and added for the current quarter's reporting of Provider History data

Format – In increments of three. For example, three, six, nine, 12, 15, and so forth.

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: REPORT EXTRACT MONTHS: Treatment Analysis Base

Description – Number of months to be extracted and added for the current quarter's reporting of Treatment Analysis data.

Format – In increments of three. For example, three, six, nine, 12, 15, and so forth.

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: REPORT EXTRACT MONTHS: Treatment Analysis Reference

Description – Number of months extracted for Treatment Analysis reference

Format – In increments of three. For example, three, six, nine, 12, 15, and so forth.

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: SUMMARY FISCAL YEAR-TO-DATE: Recipient Begin Month

Description – The beginning of the fiscal year-to-date period is used for Member Subsystem reporting

Format – Three alphabetic characters. For example, *JAN* for January or *FEB* for February and so forth

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: SUMMARY FISCAL YEAR-TO-DATE: Provider Begin Month

Description – The beginning of the fiscal year-to-date period is used for Provider Subsystem reporting

Format – Three alphabetic characters. For example, *JAN* for January or *FEB* for February and so forth

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: Element

Description – The option's element code

Format – Alphanumeric

Features – Display only

Edit – None

To Correct – n/a

Field Name: Element Description

Description – Description of the preceding element code

Format – Alphanumeric

Features – Display only

Edit – None

To Correct – n/a

Field Name: Element Value

Description – A value indicating the option selected for the element. The Cycle Date element value is calculated using the selection criteria of the cycle dates, report extract months and summary fiscal year-to-date.

Format – Alphanumeric

Features – System calculate and plug

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you want to save changes? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_OPTION_DATES

Menu – M_SUR_OPTIONS

Data Windows – DW_CYCLE_DATES

DW_BEGIN_MONTH

DW_DISTRIBUTION

DW_CYCLE_DATES

System Features

Click **Set Dates** to update the Element Values according to the Cycle Dates, Report Extract Months, and Summary Fiscal Year to Dates selected.

Click **Save** to save any changes to the window. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Exit** to return to the Option List.

Section 4: UMR Cross-Reference Window

Introduction

The Cross-Reference Control file controls peer grouping for providers, members, and also controls cross-reference groupings of diagnosis and procedure codes for the Treatment Analysis function.

The *UMR Cross-Reference* window accesses the following functions:

- Updates a cross reference scheme for SUR reporting
- Views a utilization review cycle's cross-reference tables

This window is accessed by clicking **Cross Reference (20 file)** on the SUR Main Menu. The window is accessed using the keyboard by pressing the underscored letter/number of the SUR Main Menu button.

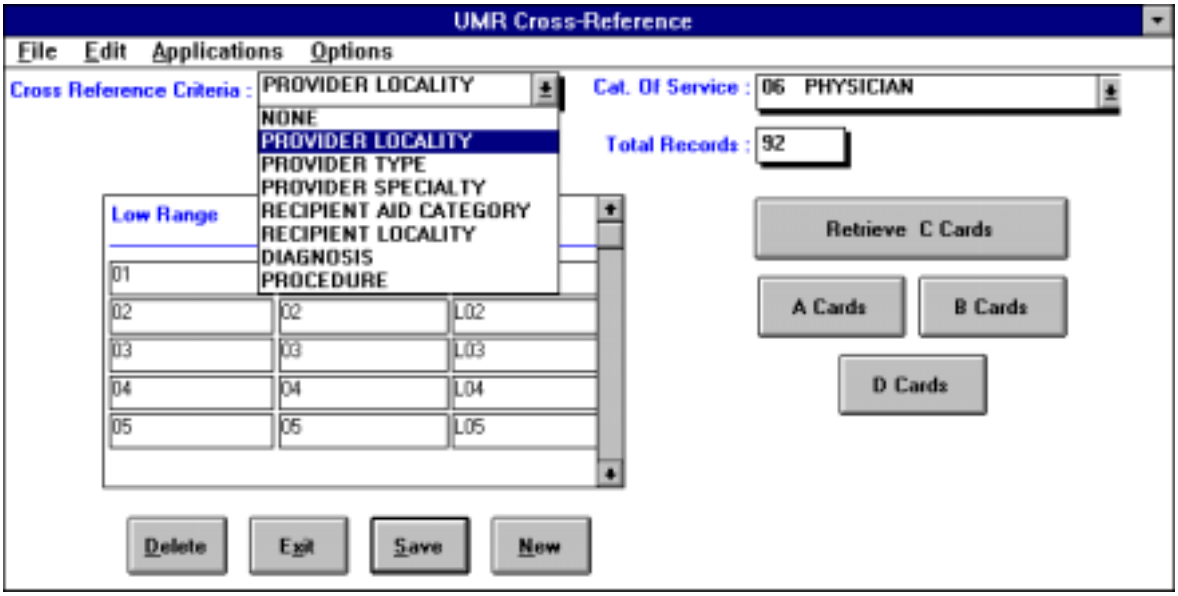


Figure 4.1 – UMR Cross-Reference Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Sort
Save	Paste	Cross Reference (20 File)	
Delete	Cut	Selected Providers (30 File)	Retrieve Xref 'C'
Print		Summary Profile (40 File)	Xref 'A' Cards
Exit		LTC Select Providers (50 File)	Xref 'B' Cards
Exit Indiana*AIM*		Selected Member (60 File)	Xref 'D' Cards
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 4.2 – UMR Cross-Reference Window Menu Tree

This is the menu bar for the *UMR Cross-Reference* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Allows the user to add a new 'C' Card

Save – Saves changes made to window

Delete – Deletes selected 'C' Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copy text to another area or application

Paste – Paste, cut, or copy from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control file for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control file for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Sort – Sorts the records in the *UMR Cross-Reference* window

Retrieve Xref 'C' Cards – Accesses the *UMR Cross-Reference* window

Xref 'A' Cards – Accesses the *UMR XREF 'A' Cards* window

Xref 'B' Cards – Accesses the *UMR XREF 'B' Cards* window

Xref 'D' Cards – Accesses the *UMR XREF 'D' Cards* window

Field Information

Field Name: Cross Reference Criteria

Description – The reporting criteria is cross referenced

Format – Valid values include the following:

- Provider Locality
- Provider Type
- Provider Specialty
- Member Aid Category
- Member Locality
- Diagnosis
- Procedure

Features – Drop-down box

Edit – None

To Correct – n/a

Field Name: Cat Of Service

Description – Cross Referencing applies to the category of service.

Format – Valid values include the following:

- 00—Default
- 01—Inpatient
- 03—Outpatient
- 04—PCCM
- 06—Physician
- 07—Pharmacy
- 08—Suppliers
- 11—Lab/Xray/Splt. Clinic
- 13—Transportation/Sp Svc
- 14—Long Term Care
- 20—Therapy Services
- 22—Mental Health
- 23—Dental/Optometric
- 33—Waiver Programs

Features – Drop-down box

Edit – 80022, Select the cross-reference type before COS.

To Correct – Select the cross-reference criteria

Edit – 80023, No records for selected XREF and COS choice.

To Correct – Select a valid, existing cross reference and category combination, or create records for the cross reference and category selected

Edit – 80030, At least Xref criteria should be selected.

To Correct – Select the cross reference criteria

Field Name: Total Records

Description – Total number of **C** cards on file for the cross reference criteria and category of service selected

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Low Range

Description – Original from value in a range of original values for the cross reference criteria selected

Format – Seven alphanumeric characters

Features – None

Edit – 91006, Field is required.

To Correct – Type a low range

Edit – 80024, C card must have corresponding D card.

To Correct – Type in a corresponding D card

Edit – Invalid range, range already exists.

To Correct – Delete duplicate range

Field Name: High Range

Description – Original to value in a range of original values for the cross reference criteria selected

Format – Seven alphanumeric characters

Features – None

Edit – 91006, Field is required.

To Correct – Type in a high range

Edit – 80024, C card must have corresponding D card.

To Correct – Type in a corresponding D card

Edit – 80009, Invalid range, low range > high range.

To Correct – Verify and type in a high range > low range

Edit – 80011, Entered an overlapping range.

To Correct – Delete duplicate range

Field Name: XRef Value

Description – Cross reference value that the associated original values are assigned

Format – Seven alphanumeric characters

Features – None

Edit – 80026, C card must have corresponding B card.

To Correct – Type in a corresponding B card

Edit – 91006, Field is required.

To Correct – Type in an xref value

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_XREF_MAINTENANCE ('C' CARD WINDOW)

Called windows – W_SUR_XREF_20FL_ACARDS

W_SUR_XREF_20FL_BCARDS

W_SUR_XREF_20FL_CCARDS

W_SUR_XREF_20FL_DCARDS

Menu – M_SUR_OPTIONS

Data Windows – DW_XREF_HDR (CROSS REFERENCE CRITERIA DW)

DW_XREF_HDR1 (CATEGORY OF SERVICE DW)

DW_XREFC_CARDS

System Features

Click **New** to create a new record at the end.

Click **Save** to save any changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete entries from the window. **Delete** allows for multiple simultaneous deletions. To delete one or more entries double-click the appropriate entry that highlights the entry. Once **Delete** is clicked, the user is prompted with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the SUR Main Menu.

Section 5: UMR XREF 'A' Cards Window

Introduction

The Cross-Reference Control File controls peer grouping for providers, members, and also controls cross-reference groupings of diagnosis and procedure codes for the Treatment Analysis function.

The UMR XREF 'A' Cards window performs the following functions:

- Updates a cross reference default value for SUR reporting
- Views a utilization review cycle's cross-reference tables

This window is accessed by clicking **A Cards** on the *UMR Cross-Reference* window using the keyboard, by pressing **Alt** plus the letter **O** to access the Options menu, then press **X**.

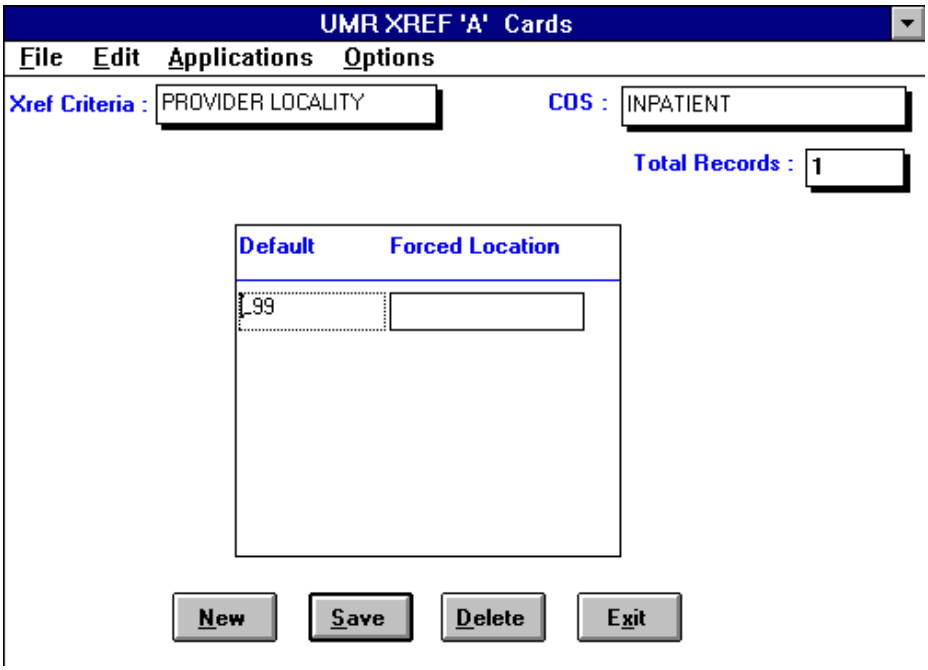


Figure 5.1 – UMR XREF 'A' Cards Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Retrieve Xref 'C'
Save	Paste	Cross Reference (20 File)	Xref 'A' Cards
Delete	Cut	Selected Providers (30 File)	Xref 'B' Cards
Print		Summary Profile (40 File)	Xref 'D' Cards
Exit		LTC Select Providers (50 File)	
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 5.2 – UMR XREF 'A' Cards Window Menu Tree

This is the menu bar for the *UMR XREF 'A' Cards* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title**.**
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new 'A' Card

Save – Saves changes made to window

Delete – Deletes selected 'A' Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application.

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Retrieve Xref 'C' Cards – Accesses the *UMR Cross-Reference* window

Xref 'A' Cards – Accesses the *UMR XREF 'A' Cards* window

Xref 'B' Cards – Accesses the *UMR XREF 'B' Cards* window

Xref 'D' Cards – Accesses the *UMR XREF 'D' Cards* window

Field Information

Field Name: Xref Criteria

Description – Reporting criteria selected on the *UMR Cross-Reference* window

Format – Valid values include the following:

- Provider Locality
- Provider Type
- Provider Specialty
- Member Aid Category
- Member Locality
- Diagnosis
- Procedure

Features – Display only

Edit – None

To Correct – n/a

Field Name: COS

Description – Category of service selected on the *UMR Cross-Reference* window

Format – Valid values include the following:

- 00—Default
- 01—Inpatient
- 03—Outpatient
- 04—Pccm
- 06—Physician
- 07—Pharmacy
- 08—Suppliers
- 11—Lab/Xray/Splt. Clinic
- 13—Transportation/Sp Svc
- 14—Long Term Care
- 20—Therapy Services
- 22—Mental Health
- 23—Dental/Optometric
- 33—Waiver Programs

Features – Display only

Edit – None

To Correct – n/a

Field Name: Total Records

Description – Total number of **A** cards on file for the cross reference criteria and category of service selected

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Default

Description – Default value to be assigned to records not meeting the specific criteria established for the category of service.

Format – Seven alpha/numeric characters

Features – None

Edit – 91006, Field is required.

To Correct – Type a default cross-reference value

Field Name: Forced Location

Description – Locality code for records that are forced, if specified

Format – Three alphanumeric or blank

Features – None

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_XREF_20FL_ ACARDS ('A' CARD WINDOW)

Menu – M_SUR_OPTIONS

Data Window – DW_XREFA_CARDS

System Features

Click **New** to create a new record at the end.

Click **Save** to save any changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete selected entries from the window. When **Delete** is clicked, the user is prompted with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the *UMR Cross-Reference* window.

Section 6: UMR XREF 'B' Cards Window

Introduction

The Cross-Reference Control File controls peer grouping for providers, members, and also controls cross-reference groupings of diagnosis and procedure codes for the Treatment Analysis function.

The *UMR XREF 'B' Cards* window performs the following functions:

- Updates a cross reference value's description for SUR reporting
- Views a Utilization Review cycle's cross-reference tables

This window is accessed by clicking **B Cards** on the *UMR Cross-Reference* window or on the keyboard by pressing **Alt** plus the letter **O** to access the Options menu, then press **B**.

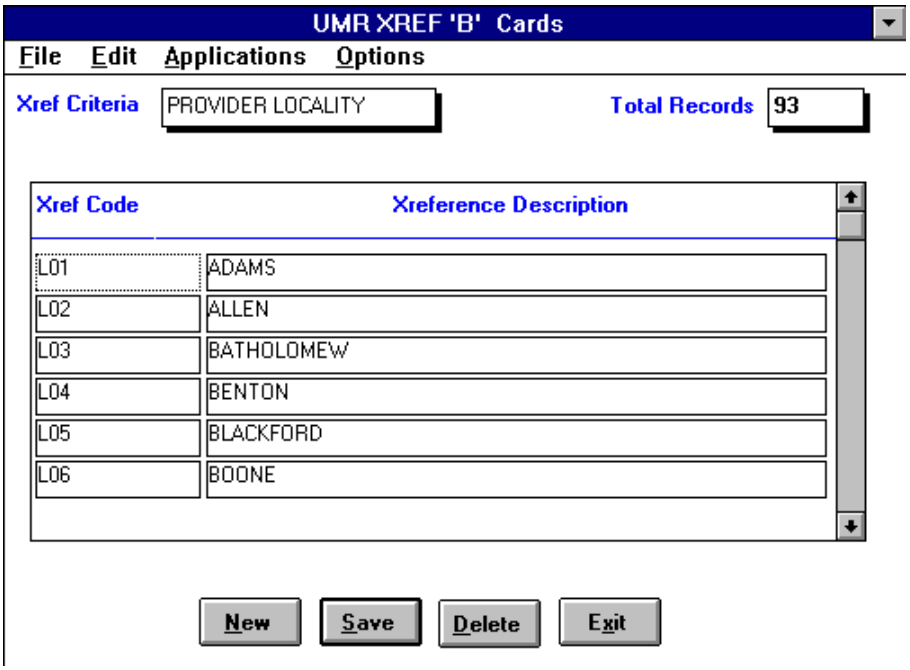


Figure 6.1 – UMR XREF 'B' Cards Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Sort
Save	Paste	Cross Reference (20 File)	Retrieve Xref 'C'
Delete	Cut	Selected Providers (30 File)	Xref 'A' Cards
Print		Summary Profile (40 File)	Xref 'B' Cards
Exit		LTC Select Providers (50 File)	Xref 'D' Cards
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 6.2 – UMR XREF 'B' Cards Window Menu Tree

This is the menu bar for the *UMR XREF 'B' Cards* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title**.**
2. Click on the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new 'B' Card

Save – Saves changes made to window

Delete – Deletes selected 'B' Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selelction accesses windows that relate to the control file.

Sort – Sorts the records in the *UMR Xref 'B' Cards* Window by Xref Code

Retrieve Xref 'C' Cards – Accesses the *UMR Cross-Reference* window

Xref 'A' Cards – Accesses the *UMR XREF 'A' Cards* window

Xref 'B' Cards – Accesses the *UMR XREF 'B' Cards* window

Xref 'D' Cards – Accesses the *UMR XREF 'D' Cards* window

Field Information

Field Name: Xref Criteria

Description – Reporting criteria selected on the *UMR Cross-Reference* window

Format – Valid values include the following:

- Provider Locality
- Provider Type
- Provider Specialty
- Member Aid Category
- Member Locality
- Diagnosis
- Procedure

Features – Display only

Edit – None

To Correct – n/a

Field Name: Total Records

Description – Total number of **B** cards on file for the cross reference criteria selected

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Xref Code

Description – Cross reference value that the original values are associated on the **C** cards

Format – Nine alphanumeric characters

Features – None

Edit – Data Window Error - Item 'xxxxxxxxx' (where "x" is the value typed) does not pass validation test.

To Correct – Verify and retype in valid Xref code

Field Name: Xreference Description

Description – Description associated with the xref code for SURS reporting

Format – 56 alphanumeric characters

Features – None

Edit – 91006, Field is required.

To Correct – Type a cross-reference description

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_XREF_20FL_ BCARDS ('B" CARD WINDOW)

Menu – M_SUR_OPTIONS

Data Window – DW_XREFB_CARDS

System Features

Click **New** to create a new record at the end.

Click **Save** to save any changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete selected entries from the window. When **Delete** is clicked, the user is prompted with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* will then appear.

Click **Exit** to return to the *UMR Cross-Reference* window.

Section 7: UMR XREF 'D' Cards Window

Introduction

The Cross-Reference Control file controls peer grouping for providers, members, and also controls cross-reference groupings of diagnosis and procedure codes for the Treatment Analysis function.

The *UMR XREF 'D' Cards* window performs the following functions:

- Updates a detail value's description for SUR reporting
- Views a utilization review cycle's cross-reference tables

This window is accessed by clicking **D Cards** on the *UMR Cross-Reference* Window. The window is accessed from the *UMR Cross-Reference* Window using the keyboard, by pressing **Alt** plus the letter **O** to access the Options menu, then press **F**.

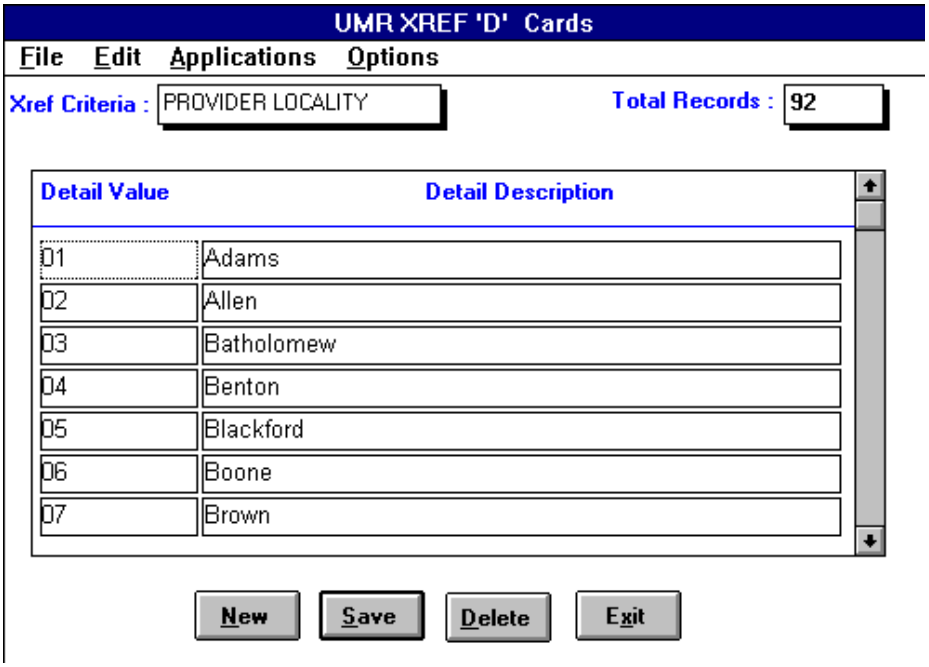


Figure 7.1 – UMR XREF 'D' Cards Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Sort
Save	Paste	Cross Reference (20 File)	Retrieve Xref 'C'
Delete	Cut	Selected Providers (30 File)	Xref 'A' Cards
Print		Summary Profile (40 File)	Xref 'B' Cards
Exit		LTC Select Providers (50 File)	Xref 'D' Cards
Exit Indiana*AIM*		Selected Reipient (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 7.2 – UMR XREF 'D' Cards Window Menu Tree

This is the menu bar for the *UMR XREF 'D' Cards* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. If a command or window option is faded, the command or window option is not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click on the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new 'D' Card

Save – Saves changes made to window

Delete – Deletes selected 'D' Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Sort – Sorts records in the UMR XREF 'D' Cards window by detail value

Retrieve Xref 'C' Cards – Accesses the *UMR Cross-Reference* window

Xref 'A' Cards – Accesses the *UMR XREF 'A' Cards* window

Xref 'B' Cards – Accesses the *UMR XREF 'B' Cards* window

Xref 'D' Cards – Accesses the *UMR XREF 'D' Cards* window

Field Information

Field Name: Xref Criteria

Description – Reporting criteria selected on the *UMR Cross-Reference* window

Format – Valid values include the following:

- Provider Locality
- Provider Type
- Provider Specialty
- Member Aid Category
- Member Locality
- Diagnosis
- Procedure

Features – Display only

Edit – None

To Correct – n/a

Field Name: Total Records

Description – Total number of **D** cards on file for the cross reference criteria selected

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Detail Value

Description – Detail values associated with cross reference values on the **C** cards

Format – Seven alphanumeric characters

Features – None

Edit – 91006, Field is required.

To Correct – Type a detail value code

Field Name: Detail Description

Description – Description associated with the detail code for SURS reporting

Format – 56 alphanumeric characters

Features – None

Edit – 91006, Field is required.

To Correct – Type in a detail description.

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_XREF_20FL_ DCARDS ('D' CARD WINDOW)

Menu – M_SUR_OPTIONS

Data Window – DW_XREFD_CARDS

System Features

Click **New** to create a new record at the end.

Click **Save** to save any changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete selected entries from the window. When **Delete** is clicked, the user is prompted with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* will then appear.

Click **Exit** to return to the *UMR Cross-Reference* window

Section 8: SUR Provider Summary/TA Select Window

Introduction

The *SUR Provider Summary/TA Select* window is used to specify providers for a summary profile or treatment analysis profile is automatically generated.

This window is accessed by clicking **Selected Providers (30 file)** on the SUR Main Menu or by pressing **Alt** plus **3** on the keyboard.

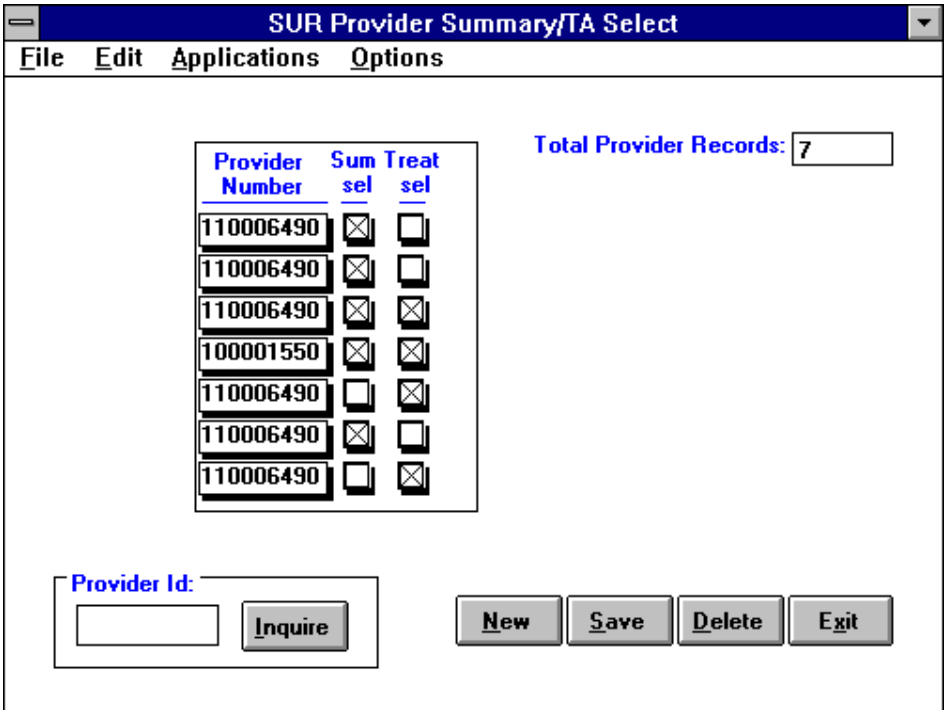


Figure 8.1 – SUR Provider Summary/TA Select Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Inquire
Save	Paste	Cross Reference (20 File)	Sort
Delete	Cut	Selected Providers (30 File)	
Print		Summary Profile (40 File)	
Exit		LTC Select Providers (50 File)	
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 8.2 – SUR Provider Summary/TA Select Window Menu Tree

This is the menu bar for the *SUR Provider Summary/TA Select* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Save – Saves changes made to window

Delete – Deletes a record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Click to display the records currently on file

Sort – Click to sort the records currently on file

Field Information

Field Name: Provider Number

Description – Medicaid identification number of the provider

Format – Nine numeric characters

Features – None

Edit – 91019, Record already exists.

To Correct – Verify typing. The provider number typed is a duplicate.

Edit – 91038, Provider number must be nine characters

To Correct – Verify typing and enter valid nine numeric provider number

Edit – 4146, Invalid provider number.

To Correct – Verify typing. The provider number typed is not enrolled in the Indiana Health Coverage Programs (IHCP).

Field Name: Sum sel

Description – An **X** in this field indicates that a Selected Provider Summary Profile Report is requested for the provider

Format – X

Features – System plug X when field is clicked with mouse

Edit – 80007, Either Summary or Treatment must be selected

To Correct – Error occurs when **Save** is clicked before selecting either sum sel or treatment sel. Select summary or treatment by clicking the **Sum Sel** and/or **Treat Sel** fields for the provider.

Field Name: Treat sel

Description – An **X** in this field indicates if a Provider Treatment Exception Report is requested for the provider

Format – X

Features – System plug X when field is clicked with mouse

Edit – 80007, Either Summary or Treatment must be selected.

To Correct – Error occurs when **Save** is clicked before selecting either sum sel or treatment sel. Select summary or treatment by clicking on the **Sum Sel** and/or **Treat Sel** fields for the provider.

Field Name: Total Provider Records

Description – Total number of records displayed

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SELECT_PROV

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_SELECT_PROV

System Features

Click **New** to add providers.

Click **Save** to save any changes in the window including new entries, changes and deletions after the last save. The system confirms that a save was successful with the message *Save Successful*. If the information is not be saved, the system prompts with the message *Save Unsuccessful*. All errors must be corrected before the save successful message appears.

Click **Delete** to delete providers. The system prompts with the message *Do you really want to delete this record?* before the deletion occurs. The system confirms the delete with the message *Delete Successful* or *Delete Unsuccessful*.

Click **Exit** to close the current window and return to the SUR Main Menu.

Click **Inquire** to enter a provider number and locate a specific provider in the table. If no provider number is entered and **Inquire** is clicked, all providers currently in the table appear. If the specific provider is not found, an error message informs that the provider number is not on the table.

Section 9: SUR Summary Profile Maintenance Window

Introduction

The *Summary Profile Line Item Control File* window controls the data to be reported within the provider and beneficiary summary profile functions.

The *SUR Summary Profile Maintenance* window performs the following functions:

- Defines and updates provider specialty **A** cards for report image assignment
- Defines and updates member aid category **A** cards for report image assignment
- Accesses report definition **D** and **E** card windows
- Accesses extract definition **D** and **E** card windows

The *SUR Summary Profile Maintenance* window is accessed by clicking **Summary Profile (40 file)** on the SUR Main Menu, or by pressing **Alt** plus **4** on the keyboard.

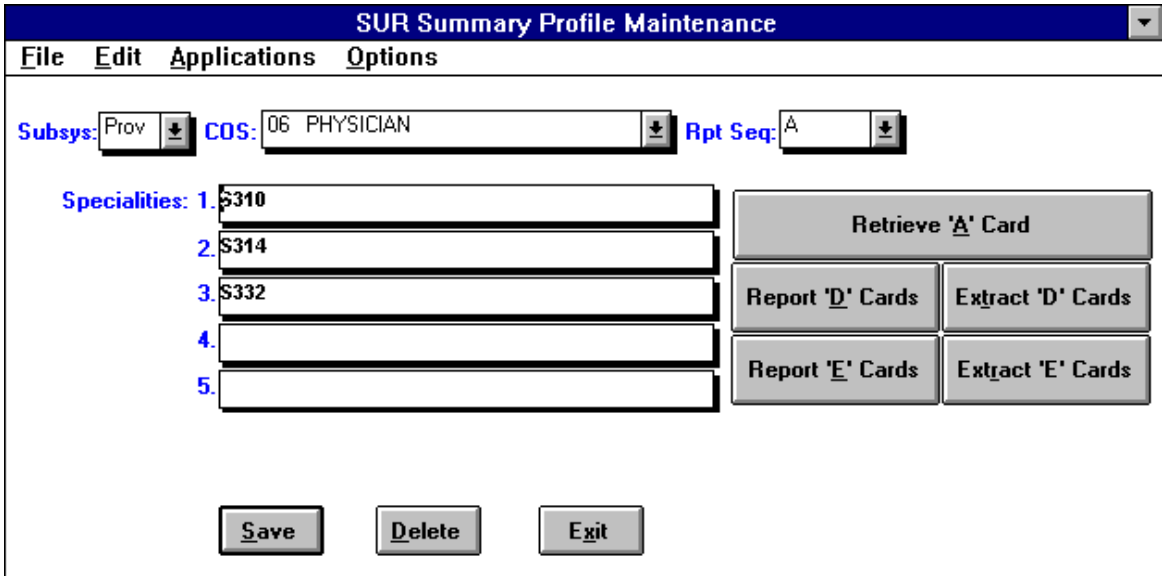


Figure 9.1 – SUR Summary Profile Maintenance Window

File	Edit	Applications	Options
Save	Copy	Option List (10 File)	Retrieve 'A' Cards
Delete	Paste	Cross Reference (20 File)	Report 'D' Cards
Print	Cut	Selected Providers (30 File)	Report 'E' Cards
Exit		Summary Profile (40 File)	Extract 'D' Cards
Exit Indiana*AIM*		LTC Select Providers (50 File)	Extract 'E' Cards
		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 9.2 – SUR Summary Profile Maintenance Window Menu Tree

This is the menu bar for the *SUR Summary Profile Maintenance* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click on the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

Save – Saves changes made to window

Delete – Deletes selected **A** Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Retrieve 'A' Cards – Accesses the Summary Profile Maintenance 'A' Cards

Report 'D' Cards – Accesses the *Report 'D' Cards* window

Report 'E' Cards – Accesses the *Report 'E' Cards* window

Extract 'D' Cards - Accesses the *Extract 'D' Cards* window

Extract 'E' Cards - Accesses the *Extract 'E' Cards* window

Field Information

Field Name: Subsys

Description – Subsystem accessed by selecting either provider or member

Format – Provider or member

Features – Drop-down box. Valid values include the following:

- Provider
- Member

Edit – Value required for this item.

To Correct – Select whether a change, addition, or deletion effects the provider or member summary extract cards

Field Name: COS

Description –SURS category of service that the user wants to access

Format – Valid values include the following:

- 01—Inpatient
- 03—Outpatient
- 04—PCCM
- 06—Physician
- 07—Pharmacy
- 08—Suppliers
- 11—Lab/Xray/Splt. Clinic
- 13—Transportation/Sp Svc
- 14—Long Term Care
- 20—Therapy Services
- 22—Mental Health
- 23—Dental/Optometric
- 33—Waiver Programs

Features – Drop-down box

Edit – 80034, Category of Service must be selected for providers.

To Correct – Choose the category of service to modify

Field Name: Rpt Seq

Description – Within each COS, nine different sets of line items (report sequences) are available. The ninth set, **Z**, is considered the 'default' activity summary and applies to all providers in the COS whose specialty is not specified elsewhere.

Format – A, B, C, D, E, F, G, H, Z

Features – Drop-down box

Edit – 80035, Report Sequence must be selected.

To Correct – Choose the appropriate report sequence

Field Name: Specialties 1-5

Description – Cross-reference specialty codes to be reported in the selected report sequence for the COS

Format – Four alphanumeric characters

Features – None

Edit – DataWindow Error, Item 'X' does not pass the validation test (where 'X' = the value typed).

To Correct – Verify and type in a valid specialty cross-reference code

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SUMMARY_PROFILE - Calls data-windows for A card and windows for other cards

Called windows – W_SUR_REPORT_D_CARDS

W_SUR_REPORT_E_CARDS

W_SUR_EXTRACT_D_CARDS

W_SUR_EXTRACT_E_CARDS

Menu – M_SUR_OPTIONS

Data Windows – DW_40_RPT_D

DW_40_RPT_E

DW_40_EXT_D

DW_40_EXT_E

DW_40_PROV_A (CALLED FROM W_SUR_SUMMARY_PROFILE)

DW_40_BENE_A (CALLED FROM W_SUR_SUMMARY_PROFILE)

System Features

Click **Retrieve 'A' Card** to allow entry of cross-reference specialty values for report sequence assignment.

Click **Report 'D' Cards** to open the *Report 'D' cards* window to allow card maintenance.

Click **Report 'E' Cards** to open the *Report 'E' cards* window to allow card maintenance.

Click **Extract 'D' Cards** to open the *Extract 'D' cards* window to allow card maintenance.

Click **Extract 'E' Cards** to open the *Extract 'E' cards* window to allow card maintenance.

Click **Retrieve 'A' Card** to open the *'A' card* window to allow card maintenance.

Save and **Delete** are activated only when **Retrieve 'A' Card** is activated.

Click **Exit** to return to the SUR Main Menu.

Section 10: Report 'D' Cards Window

Introduction

The Summary Profile Line Item Control file controls the data reported within the provider and beneficiary summary profile functions.

The *Report 'D' Cards* window performs the following functions:

- Defines the actual verbiage to be used as the line item description on the report
- Indicates title lines for display on the summary profile
- Applies exception limits to a summary profile line
- Applies forced exception indicators to a summary profile line

This window is accessed by clicking **Report 'D' Cards** on the *SUR Summary Profile Maintenance* window.

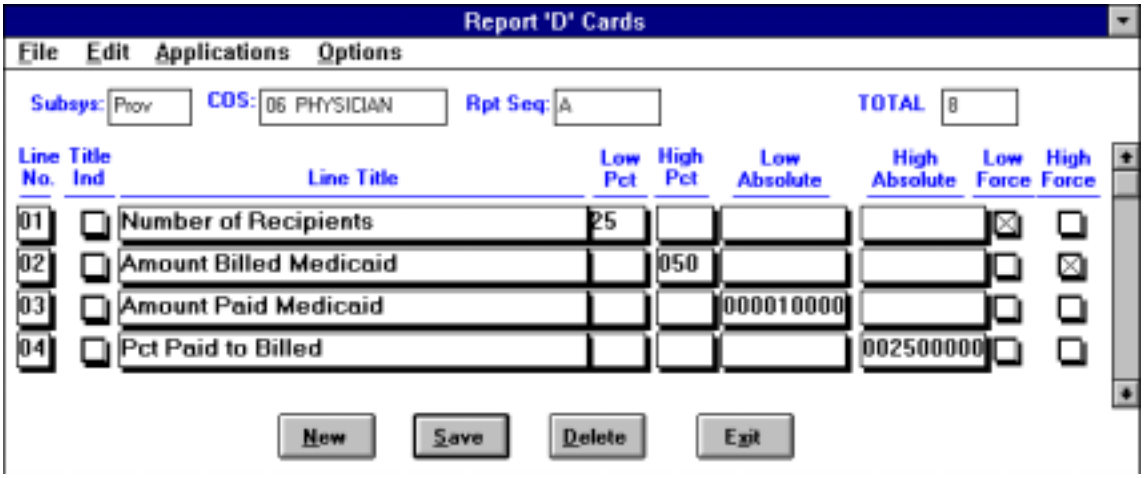


Figure 10.1 – Report ‘D’ Cards Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Sort
Save	Paste	Cross Reference (20 File)	Retrieve 'A' Cards
Delete	Cut	Selected Providers (30 File)	Report 'D' Cards
Print		Summary Profile (40 File)	Report 'E' Cards
Exit		LTC Select Providers (50 File)	Extract 'D' Cards
Exit Indiana*AIM*		Selected Member (60 File)	Extract 'E' Cards
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 10.2 – Report 'D' Cards Window Menu Tree

This is the menu bar for the *Report 'D' Cards* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new Report 'D' Card

Save – Saves changes made to window

Delete – Deletes selected Report 'D' Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Sort – Sorts the records on file.

Retrieve 'A' Cards – Accesses the Summary Profile Maintenance 'A' Cards

Report 'D' Cards – Accesses the *Report 'D' Cards* window

Report 'E' Cards – Accesses the *Report 'E' Cards* window

Extract 'D' Cards – Accesses the *Extract 'D' Cards* window

Extract 'E' Cards – Accesses the *Extract 'E' Cards* window

Field Information

Field Name: Subsys

Description – Updates applied to the subsystem on the *SUR Summary Profile Maintenance* window

Format – Provider or member

Features – Display only

Edit – None

To Correct – n/a

Field Name: COS

Description – Updates applied to the SURS category of service on the *SUR Summary Profile Maintenance* window

Format – Two numeric characters: 01 through 99

Features – Display only

Edit – None

To Correct – n/a

Field Name: Rpt Seq

Description – Updates applied to the report sequence on the *SUR Summary Profile Maintenance* window

Format – One alphabetic charater: A, B, C, D, E, F, G, H, Z

Features – Display only

Edit – None

To Correct – n/a

Field Name: TOTAL

Description – Total number of Report D records carried on file for the subsystem/category of service/report sequence

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Line No.

Description – Line sequence assigned to the line item

Format – Two numeric characters: 01 through 99

Features – None

Edit – 80014, Line number must be numeric, 01-99.

To Correct – Verify typing and enter numeric value from 01 to 99

Field Name: Title Ind

Description – An **X** in this field indicates that the line item is a title line, and will not have associated data extracts and calculations

Format – X

Features – System plugs **X** when field is clicked with mouse

Edit – None

To Correct – n/a

Field Name: Line Title

Description – Description of the line as it appears on the summary report

Format – 32 alphanumeric characters

Features – None

Edit – None

To Correct – n/a

Field Name: Low Pct

Description – Value of the low percentage exception limit if exception processing for values less than the peer group average is desired

Format – Three numeric characters

Features – None

Edit – 80015, Low percent range must be 01-99 or blank.

To Correct – Verify typing and enter a value from 01-99.

Field Name: High Pct

Description – Value of the high percentage exception limit if exception processing for values greater than the peer group average is desired

Format – Three numeric characters

Features – None

Edit – 80016, High percent range must be 001-100 or blank.

To Correct – Verify typing and enter a value from 001-100.

Field Name: Low Absolute

Description – Value to be used as the low exception limit if exception processing for values less than the low absolute limit is desired

Format – Nine numeric characters (two implied decimals)

Features – None

Edit – 80017, Low absolute must be nine digits or blank.

To Correct – Verify keying and enter nine numeric digits (leading zeros are required)

Edit – Low absolute must be numeric.

To Correct – Verify typing and enter nine numeric digits

Field Name: High Absolute

Description – Value to be used as the high exception limit if exception processing for values greater than the high absolute limit is desired

Format – Nine numeric characters (two implied decimals)

Features – None

Edit – 80018, High absolute must be nine digits or blank.

To Correct – Verify typing and enter nine numeric digits (leading zeros are required)

Field Name: Low Force

Description – An **X** in this field indicates that a forced exception report will be produced for individuals who fail the low exception limit for this line

Format – X

Features – System plugs an **X** when the field is clicked with mouse

Edit – None

To Correct – n/a

Field Name: High Force

Description – An **X** in this field indicates that a forced exception report will be produced for individuals who fail the high exception limit for this line

Format – X

Features – System plugs an **X** when this field is clicked with mouse

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SUMMARY_PROFILE - Calls data-windows for A card and windows for other cards

Called windows – W_SUR_REPORT_D_CARDS

W_SUR_REPORT_E_CARDS

W_SUR_EXTRACT_D_CARDS

W_SUR_EXTRACT_E_CARDS

Menu – M_SUR_OPTIONS

Data Windows – DW_40_RPT_D

DW_40_RPT_E

DW_40_EXT_D

DW_40_EXT_E

DW_40_PROV_A (CALLED FROM W_SUR_SUMMARY_PROFILE)

DW_40_BENE_A (CALLED FROM W_SUR_SUMMARY_PROFILE)

System Features

Click **New** to create a new record at the end.

Click **Save** to save changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete selected entries from the window. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the *SUR Summary Profile Maintenance* window.

Section 11: Report 'E' Cards Window

Introduction

The Summary Profile Line Item Control file controls the data reported within the Provider and Beneficiary summary profile functions.

The *Report 'E' Cards* window defines the category codes, accumulation codes, and the equation to be used in computing the value of each line item.

This window is accessed by clicking **Report 'E' Cards** on the *SUR Summary Profile Maintenance* Window.

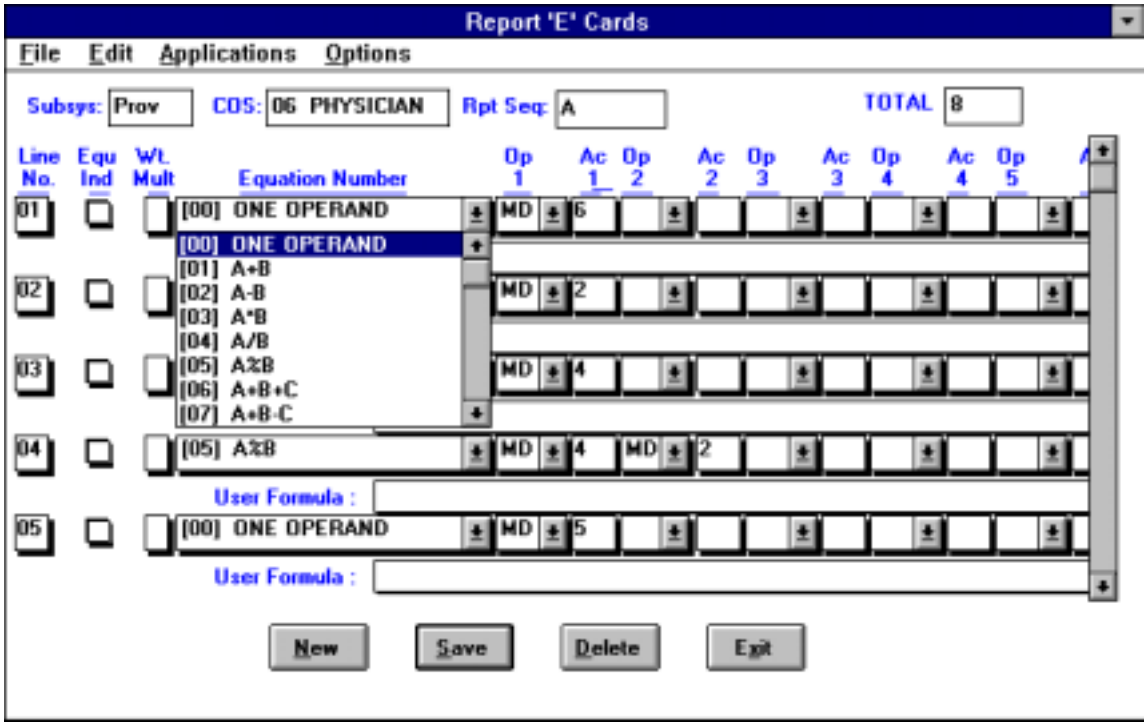


Figure 11.1 – Report 'E' Cards Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Sort
Save	Paste	Cross Reference (20 File)	Retrieve 'A' Cards
Delete	Cut	Selected Providers (30 File)	Report 'D' Cards
Print		Summary Profile (40 File)	Report 'E' Cards
Exit		LTC Select Providers (50 File)	Extract 'D' Cards
Exit Indiana*AIM*		Selected Member (60 File)	Extract 'E' Cards
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 11.2 – Report 'E' Cards Window Menu Tree

This is the menu bar for the *Report 'E' Cards* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click on the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new Report 'E' Card

Save – Saves changes made to window

Delete – Deletes selected Report 'E' Cards

Print – Prints a data window, current window, or the entire screen.

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Sort – Allows the user to sort the record on file

Retrieve 'A' Cards – Accesses the Summary Profile Maintenance 'A' Cards

Report 'D' Cards – Accesses the *Report 'D' Cards* window

Report 'E' Cards – Accesses the *Report 'E' Cards* window

Extract 'D' Cards – Accesses the *Extract 'D' Cards* window

Extract 'E' Cards – Accesses the *Extract 'E' Cards* window

Field Information

Field Name: Subsys

Description – Updates are applied to the subsystem on the *SUR Summary Profile Maintenance* window

Format – Provider or member

Features – Display only

Edit – None

To Correct – n/a

Field Name: COS

Description – Updates are applied to the SURS category of service on the *SUR Summary Profile Maintenance* window

Format – Two numeric characters: 01 through 99

Features – Display only

Edit – None

To Correct – n/a

Field Name: Rpt Seq

Description – Updates are applied to the report sequence on the *SUR Summary Profile Maintenance* window

Format – A, B, C, D, E, F, G, H, Z

Features – Display only

Edit – None

To Correct – n/a

Field Name: TOTAL

Description – Total number of Report E records carried on file for the subsystem/category of service/report sequence

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Line No.

Description – Line sequence assigned to the line item

Format – Two numeric characters: 01 through 99

Features – None

Edit – 80014, Line number must be numeric, 01-99.

To Correct – Verify typing and enter numeric value from 01 to 99

Field Name: Equ Ind

Description – An **X** in this field indicates that a "free form" equation is used for calculation of this line item. The free form equation is coded in the USER FORMULA field.

Format – X

Features – System plugs an **X** when this field is clicked with mouse

Edit – None

To Correct – n/a

Field Name: Wt Mult

Description – Multiplication factor used in the reference period weight calculation

Format – 0 through 9

Features – None

Edit – 80019, Weight multiplier must be in range 1-9 or blank.

To Correct – Verify typing and enter numeric value 1-9 or leave blank

Field Name: Equation Number

Description – Formula code of the equation used in the calculation of the line item

Format – See Table 11.1

Table 11.1 – Equation Number Field Format

Line Item	Formula Code	Line Item	Formula Code	Line Item	Formula Code
00	ONE OPERAND	24	(A%B)*C	48	(A-B)%(C+D)
01	A+B	25	(A*B)%C	49	(A-B)%(C+D)
02	A-B	26	A+B+C+D	50	A+B+C+D+E
03	A*B	27	A+B+C-D	51	A+B+C-D-E
04	A/B	28	(A+B)/(C+D)	52	A+B-C-D-E
05	A%B	29	(A+B)%(C+D)	53	(A+B+C)/(D+E)
06	A+B+C	30	(A+B)/(C-D)	54	(A+B+C)%(D+E)
07	A+B-C	31	(A-B)/(C-D)	55	(A+B-C)/(D+E)
08	A+(B*C)	32	(A-B)%(C-D)	56	(A+B-C)%(D+E)
09	A+(B/C)	33	(A+B+C)/D	57	(A+B+C)/(D-E)
10	A-B+C	34	(A+B+C)%D	58	(A+B+C)%(D-E)
11	A-B-C	35	(A+B-C)/D	59	(A-B-C)/(D+E)
12	A-(B*C)	36	(A+B-C)%D	60	(A-B-C)%(D+E)
13	A-(B/C)	37	A/(B+C+D)	61	(A-B)/(C+D+E)
14	(A+B)/C	38	A%(B+C+D)	62	(A-B)%(C+D+E)
15	(A+B)%C	39	A+B-C-D	63	(A+B)/(C+D-E)
16	(A-B)/C	40	A-B-C-D	64	(A+B)%(C+D-E)
17	(A-B)%C	41	(A-B-C)/D	65	(A-B)/(C+D-E)
18	A/(B+C)	42	(A-B-C)%D	66	(A-B)%(C+D-E)
19	A/(B-C)	43	A/(B+C-D)	67	(A+B)/(C-D-E)
20	A%(B+C)	44	A%(B+C-D)	68	(A+B)%(C-D-E)
21	A%(B-C)	45	A/(B-C-D)	69	A-B-C-D-E
22	(A*B)/C	46	A%(B-C-D)	70	(A-B)/(C-D-E)
23	(A/B)*C	47	(A-B)/(C+D)	71	(A-B)%(C-D-E)

+	*ADDITION*
–	*SUBTRACTION*
*	*MULTIPLICATION*
/	*DIVISION*
%	*COMPUTE PERCENTAGE (read in formula as 'as a percent of-example: A%B = A as a percent of B)*

Features – Drop-down box

Edit – 80045, Equation Number must be entered.

To Correct – Select value from drop-down box

Field Name: Op 1 through 5

Description – The category code, or standard code, assigned to the extract code is used for coding the line item equation. A major category code captures the data for all minor codes in its group; for example, 20 is the major code for minor codes 21-29. There are 15 major codes available (10-F9) with 9 minor codes each, resulting in 150 available category codes to be defined.

A standard code is used to obtain information commonly required, but the extract definition is always the same. Standard codes are represented by the two alphabetic characters. For example, standard code MD accumulates data for all Medicaid services.

A combination of a category code (major, minor or standard) and an accumulation code is called an operand.

Format – Valid values include the following:

- 10, 11-19
- 20, 21-29
- 30, 31-39
- 40, 41-49
- 50, 51-59
- 60, 61-69
- 70, 71-79
- 80, 81-89
- 90, 91-99
- A0, A1-A9
- B0, B1-B9
- C0, C1-C9
- D0, D1-D9
- E0, E1-E9
- F0, F1-F9
- MD (Medicaid)
- MR (Medicare)
- MM (Medicaid and Medicare)
- DG (Diagnosis Xref Codes)
- SD (Same Day Same Drug)
- DR (Drug Refills)
- IP (Inpatient)
- PF (Professional Fees)
- RP (Drug Referring Physician)

- PH (Pharmacy Count)
- PA (Prior Authorized)
- RA (Readmissions)

Features – Drop-down box

Edit – 80048, Operand and Accumulator code must be entered.

To Correct – Enter a valid accumulator code, or select value from drop-down box

Field Name: Ac 1 through 5

Description – Accumulation code. The numeric code that indicates what type of information is to be accumulated. An accumulation code is appended to a category or standard code to form an operand.

Format – Valid values include the following:

- 1—Number of services
- 2—Amount billed
- 3—Amount allowed
- 4—Amount paid
- 5—Number of claims
- 6—Bene / Provider count
- 7—Prescribed units / quantity
- 8—Days span / supply
- 9—Occurrences

Features – Drop-down box

Edit – 80048, Operand and Accumulator code must be entered.

To Correct – Verify typing and enter numeric value or select value from drop-down box

Field Name: User Formula

Description – If **X** is coded in the EQU IND field, then a user-defined free form equation must be coded in this field. For example, (111+112+211+254)-(311+312+313)/MD6

Format – 59 alphanumeric and special characters

Features – None

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SUMMARY_PROFILE - (Calls data-windows for A card and windows for other cards)

Called windows – W_SUR_REPORT_D_CARDS

W_SUR_REPORT_E_CARDS

W_SUR_EXTRACT_D_CARDS

W_SUR_EXTRACT_E_CARDS

Menu – M_SUR_OPTIONS

Data Windows – DW_40_RPT_D

DW_40_RPT_E

DW_40_EXT_D

DW_40_EXT_E

DW_40_PROV_A (Called from w_sur_summary_profile)

DW_40_BENE_A (Called from w_sur_summary_profile)

System Features

Click **New** to create a new record at the end.

Click **Save** to save changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete selected entries from the window. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessfu*" appears.

Click **Exit** to return to the *SUR Summary Profile Maintenance* window.

Section 12: Extract 'D' Cards Window

Introduction

The Summary Profile Line Item Control file controls the data to be reported within the provider and beneficiary summary profile functions.

The *Extract 'D' Cards* window performs the following function:

- Assigns a verbal description to the data extracted within a major/minor category code, as defined by the corresponding Extract 'E' Cards. One 'D' input must be coded for each category code referenced on the extract definition E input.

This window is accessed by clicking **Extract 'D' Cards** on the *SUR Summary Profile Maintenance* window.

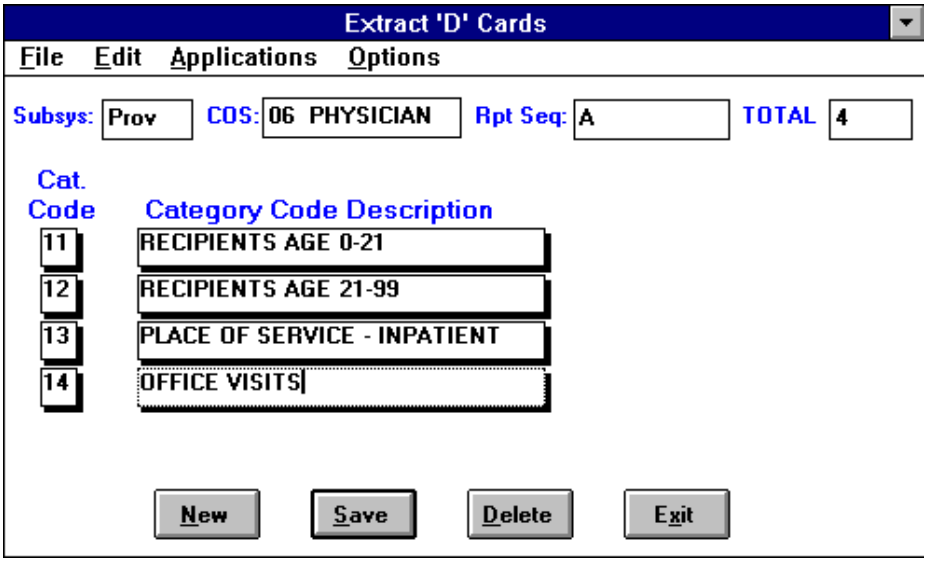


Figure 12.1 – Extract 'D' Cards Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Sort
Save	Paste	Cross Reference (20 File)	Retrieve 'A' Cards
Delete	Cut	Selected Providers (30 File)	Report 'D' Cards
Print		Summary Profile (40 File)	Report 'E' Cards
Exit		LTC Select Providers (50 File)	Extract 'D' Cards
Exit Indiana*AIM*		Selected Member (60 File)	Extract 'E' Cards
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 12.2 – Extract 'D' Cards Window Menu Tree

This is the menu bar for the *Extract 'D' Cards* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new Extract 'D' Card

Save – Saves changes made to window

Delete – Deletes selected Extract 'D' Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Sort – Sorts the records on file.

Retrieve 'A' Cards – Accesses the Summary Profile Maintenance 'A' Cards

Report 'D' Cards – Accesses the *Report 'D' Cards* window

Report 'E' Cards – Accesses the *Report 'E' Cards* window

Extract 'D' Cards – Accesses the *Extract 'D' Cards* window

Extract 'E' Cards – Accesses the *Extract 'E' Cards* window

Field Information

Field Name: Subsys

Description – Updates are applied to the subsystem on the *SUR Summary Profile Maintenance* window

Format – Provider or member

Features – Display only

Edit – None

To Correct – n/a

Field Name: COS

Description – Updates are applied to the SURS category of service on the *SUR Summary Profile Maintenance* window

Format – Two numeric characters: 01 through 99

Features – Display only

Edit – None

To Correct – n/a

Field Name: Rpt Seq

Description – Updates are applied to the report sequence on the *SUR Summary Profile Maintenance* window

Format – One alphabetic character: A, B, C, D, E, F, G, H, or Z

Features – Display only

Edit – None

To Correct – n/a

Field Name: TOTAL

Description – Total number of Extract 'D' records that are carried on file for the subsystem/category of service/report sequence

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Cat. Code

Description – Category Code value chosen as the internal reference for this data

Format – Valid values include the following:

- 10, 11-19
- 20, 21-29
- 30, 31-39
- 40, 41-49
- 50, 51-59
- 60, 61-69
- 70, 71-79
- 80, 81-89
- 90, 91-99
- A0, A1-A9
- B0, B1-B9
- C0, C1-C9
- D0, D1-D9
- E0, E1-E9
- F0, F1-F9

Features – Drop-down box

Edit – 80021, Category code must be in range 10-F9.

To Correct – Verify typing and enter value from A0 - F9, 10 - 99

Field Name: Category Code Description

Description – Description of data to be extracted as defined by the corresponding 'E' cards for this category code

Format – 35 alphanumeric characters

Features – None

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SUMMARY_PROFILE (Calls data-windows for an **A** card and windows for other cards)

Called windows – W_SUR_REPORT_D_CARDS

W_SUR_REPORT_E_CARDS

W_SUR_EXTRACT_D_CARDS

W_SUR_EXTRACT_E_CARDS

Menu – M_SUR_OPTIONS

Data Windows – DW_40_RPT_D

DW_40_RPT_E

DW_40_EXT_D

DW_40_EXT_E

DW_40_PROV_A (Called from w_sur_summary_profile)

DW_40_BENE_A (Called from w_sur_summary_profile)

System Features

Click **New** to create a new record at the end.

Click **Save** to save changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete selected entries from the window. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the *SUR Summary Profile Maintenance* window.

Section 13: Extract 'E' Cards Window

Introduction

The Summary Profile Line Item Control file controls the data reported within the Provider and Beneficiary summary profile functions.

The *Extract 'E' Cards* window performs the following functions:

- Defines the extract data type for the category code.
- Assigns extract values to the category code.

This window is accessed by clicking **Extract 'E' Cards** on the *SUR Summary Profile Maintenance* window.

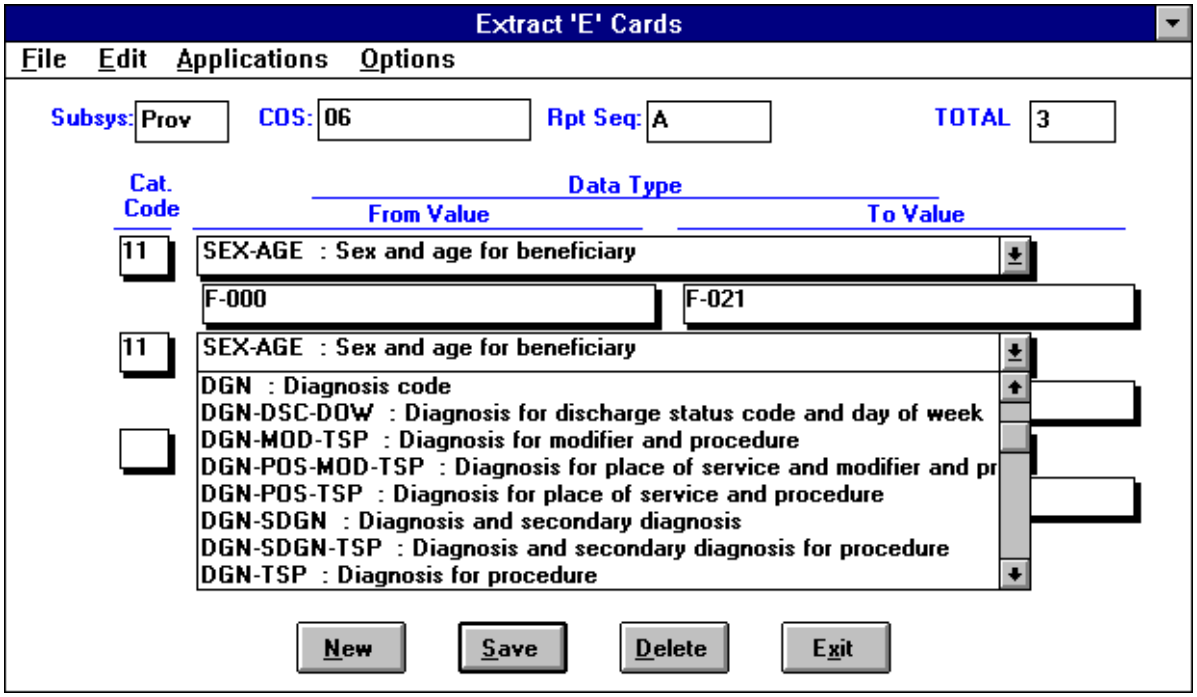


Figure 13.1 – Extract 'E' Cards Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Sort
Save	Paste	Cross Reference (20 File)	Retrieve ‘A’ Cards
Delete	Cut	Selected Providers (30 File)	Report ‘D’ Cards
Print		Summary Profile (40 File)	Report ‘E’ Cards
Exit		LTC Select Providers (50 File)	Extract ‘D’ Cards
Exit Indiana*AIM*		Selected Member (60 File)	Extract ‘E’ Cards
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 13.2 – Extract ‘E’ Cards Window Menu Tree

This is the menu bar for the *Extract 'E' Cards* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new Extract 'E' Card

Save – Saves changes made to window

Delete – Deletes selected Extract 'E' Cards

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

Exit Indiana*AIM* – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Sort – Sorts the records on file

Retrieve 'A' Cards – Accesses the Summary Profile Maintenance 'A' Cards

Report 'D' Cards – Accesses the *Report 'D' Cards* window

Report 'E' Cards – Accesses the *Report 'E' Cards* window

Extract 'D' Cards – Accesses the *Extract 'D' Cards* window

Extract 'E' Cards – Accesses the *Extract 'E' Cards* window

Field Information

Field Name: Subsys

Description – Updates are applied to the subsystem on the SUR Summary Profile Maintenance

Format – Provider or member

Features – Display only

Edit – None

To Correct – n/a

Field Name: COS

Description – Updates are applied to the SURS category of service on the *SUR Summary Profile Maintenance* window

Format – Two numeric characters: 01 through 99

Features – Display only

Edit – None

To Correct – n/a

Field Name: Rpt Seq

Description – Updates are applied to the report sequence on the *SUR Summary Profile Maintenance* window

Format – One alphabetic character: A, B, C, D, E, F, G, H, or Z

Features – Display only

Edit – None

To Correct – n/a

Field Name: TOTAL

Description – Total number of Extract E records that are carried on file for the subsystem/category of service/report sequence.

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Cat. Code

Description – Category code value that has been chosen as the internal reference for this data.

Format – Valid values include the following:

- 10, 11-19
- 20, 21-29
- 30, 31-39
- 40, 41-49
- 50, 51-59
- 60, 61-69
- 70, 71-79
- 80, 81-89
- 90, 91-99
- A0, A1-A9
- B0, B1-B9
- C0, C1-C9
- D0, D1-D9
- E0, E1-E9
- F0, F1-F9

Features – Drop-down box

Edit – 80021, Category code must be in range 10-F9.

To Correct – Verify typing and enter value from A0 - F9, 10 - 99

Field Name: Data Type

Description – Data type code assigned to the summary extract identifying the type of data to be extracted, such as procedure, place of service, EOB, and so forth

Format – See Table 13.1

Features – Drop-down box

Edit – 80040, Columns must be entered.

To Correct – Select a data type code from the drop-down box

Field Name: From Value

Description – Low value in a range of values to be extracted for the data type

Format – See Table 13.1

Features – Drop-down box

Edit – Columns must be entered.

To Correct – Enter a valid from value

Edit – Format editing depends on data type selected.

To Correct – Type in a valid format for the data type entered

Field Name: To Value

Description – High value in a range of values to be extracted for the data type

Format – See Table 13.1

Features – Drop-down box

Edit – Columns must be entered.

To Correct – Type in a valid to value

Edit – Format editing depends on Data type selected.

To Correct – Type in a valid format for the data type entered

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SUMMARY_PROFILE - (Calls data-windows for A card and windows for other cards)

Called windows – W_SUR_REPORT_D_CARDS

W_SUR_REPORT_E_CARDS

W_SUR_EXTRACT_D_CARDS

W_SUR_EXTRACT_E_CARDS

Menu – M_SUR_OPTIONS

Data Windows – DW_40_RPT_D

DW_40_RPT_E

DW_40_EXT_D

DW_40_EXT_E

DW_40_PROV_A (Called from w_sur_summary_profile)

DW_40_BENE_A (Called from w_sur_summary_profile)

System Features

Click **New** to create a new record at the end.

Click **Save** to save changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete selected entries from the window. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the *SUR Summary Profile Maintenance* window.

Table 13.1 – Summary Extract Code

Data Type	Data Type Code	Code Format
Admission for day of week	ADM-DOW	DDD
Admission for procedure	ADM-TSP	XBBBBBBBBBB
Admitting diagnosis	ADGN	AAXAAA
Admitting diagnosis for procedure	ADGN-TSP	AAXAAA-XBBBBBBBBBB
Calculated percentage value of DRG mean length of stay to be equal to or less than for each DRG	DRG-MLOS	99999 (plus control file entry)
Claim type	CLM	X
Claim type for diagnosis	CLM-DGN	X-AAXAAA
Claim type for diagnosis and procedure	CLM-DGN-TSP	X-AAXAAA-XBBBBBBBBBB
Claim type for place of service and procedure	CLM-POS-TSP	X-99-XBBBBBBBBBB
Claim type for procedure	CLM-TSP	X-XBBBBBBBBBB
Day of week for procedure	DOW-TSP	DDD-XBBBBBBBBBB
Day surgeries	IP5	(*)n/a
Days stay	IP6	(*)n/a
Diagnosis and secondary diagnosis	DGN-SDGN	AAXAAA-AAXAAA
Diagnosis and secondary diagnosis for procedure	DGN-SDGN-TSP	AAXAAA-AAXAAA-XBBBBBBBBBB
Diagnosis code	DGN	AAXAAA
Diagnosis for discharge status code and day of week	DGN-DSC-DOW	AAXAAA-XX-DDD
Diagnosis for modifier and procedure	DGN-MOD-TSP	AAXAAA-XX-XBBBBBBBBBB
Diagnosis for place of service and modifier and procedure	DGN-POS-MOD-TSP	AAXAAA-99-XX-XBBBBBBBBBB
Diagnosis for place of service and procedure	DGN-POS-TSP	AAXAAA-99-XBBBBBBBBBB
Diagnosis for procedure	DGN-TSP	AAXAAA-XBBBBBBBBBB
Diagnosis related grouping	DRG	99999
Discharge diagnosis	DSC-DGN	XX-AAXAAA

(Continued)

Table 13.1 – Summary Extract Code

Data Type	Data Type Code	Code Format
Discharge for day of week	DSC-DOW	DDD
Discharge status code	DSC	XX
Discharge status code for procedure	DSC-TSP	XX-XBBBBBBBBBB
Drug referring physician	RP	(*)n/a
Drug refill	DR	(*)n/a
Drug refill for procedure	DR-TSP	XBBBBBBBBBB
Explanation of benefit code	SCC	999
Explanation of benefit code for procedure	SCC-TSP	999-XBBBBBBBBBB
Grouper diagnosis code	GRP-DGN	AAXAAA
Grouper procedure code	GRP-PRO	XXXXX
Hospital leave days	HLD (**)	999
Length of stay	LOS	999
Length of stay for diagnosis	LOS-DGN	999-AAXAAA
Length of stay for DRG with source of admission	DRG-LOS-SOA	99999-999-9
Length of stay for procedure	LOS-TSP	999-XBBBBBBBBBB
Medicaid	MD	(*)n/a
Medicaid and Medicare	MM	(*)n/a
Medicare	MR	(*)n/a
Modifier	MOD	XX
Modifier for procedure	MOD-TSP	XX-XBBBBBBBBBB
Place of service	POS	99
Place of service for diagnosis	POS-DGN	99-AAXAAA
Place of service for diagnosis and procedure	POS-DGN-TSP	99-AAXAAA-XBBBBBBBBBB
Place of service for procedure	POS-TSP	99-XBBBBBBBBBB

(Continued)

Table 13.1 – Summary Extract Code

Data Type	Data Type Code	Code Format
Post-op days	IP4	(*)n/a
Pre-op days	IP3	(*)n/a
Prescription drug schedule code	RXS	X
Prescriptions for therapeutic class	RXC	XBBB
Prior authorization	PA	(*)n/a
Prior authorization for procedure	PA-TSP	XBBBBBBBBBB
Procedure	TSP	XBBBBBBBBBB
Provider specialty	PSP	999
Provider specialty for procedure	PSP-TSP	999-XBBBBBBBBBB
Provider type	PVT	99
Provider type for procedure	PVT-TSP	99-XBBBBBBBBBB
Readmission	RA	(*)n/a
Referring physician for procedure	RPH-TSP	XBBBBBBBBBB
Referring physician for therapeutic class	RPH-RXC	XBBB
Same day for drug therapeutic class	SMD-RXC	XBBB
Same day for place of service and procedure	SMD-POS-TSP	99-XBBBBBBBBBB
Same day for procedure	SMD-TSP	XBBBBBBBBBB
Same day same drug	SD	(*)n/a
Secondary diagnosis	SDGN	AAXAAA
Sex and age for bene	SEX-AGE	S-999
Sex and age for beneficiary	SEX-AGE	S-999
Sex and age for diagnosis	SEX-AGE-DGN	S-999-AAXAAA
Sex and age for diagnosis and procedure	SEX-AGE-DGN-TSP	S-999-AAXAAA-XBBBBBBBBBB
Sex and age for modifier and procedure	SEX-AGE-MOD-TSP	S-999-XX-XBBBBBBBBBB

(Continued)

Table 13.1 – Summary Extract Code

Data Type	Data Type Code	Code Format
Sex and age for place of service	SEX-AGE-POS	S-999-99
Sex and age for place of service and diagnosis and procedure	SEX-AGE-POS-DGN-TSP	S-999-99-AAXAAA-XBBBBBBBBBB
Sex and age for place of service and procedure	SEX-AGE-POS-TSP	S-999-99-XBBBBBBBBBB
Sex and age for procedure	SEX-AGE-TSP	S-999-XBBBBBBBBBB
Source of admission	SOA	9
Source of admission for admit day of week	SOA-ADM-DOW	9-DDD
Source of admission for diagnosis	SOA-DGN	9-AAXAAA
Source of admission for discharge day of week	SOA-DSC-DOW	9-DDD
Surgical discharges	IP2	(*)n/a
Therapeutic leave days	TLD (**)	999
Type of admission	TOA	9
Type of admission for admit day of week	TOA-ADM-DOW	9-DDD
Type of admission for diagnosis	TOA-DGN	9-AAXAAA
Type of admission for discharge day of week	TOA-DSC-DOW	9-DDD
Type of admission for procedure	TOA-TSP	9-XBBBBBBBBBB

** Standard extract codes are denoted with an asterisk and "n/a" in the code format field.*

*** Accumulator code 1 for HLD and TLD accumulates the number of days for leave days.*

Code Format Key

9 Value must be 0-9

A Value must be 0-9, A-Z, imbedded blanks

B Value must be 0-9, A-Z, trailing blanks

D Value must be MON, TUE, WED, THU, FRI, SAT, SUN

S Value must be M or F

X Value must be 0-9, A-Z

\- Value must be a dash

Section 14: LTC Provider Select Window

Introduction

The *LTC Provider Select* window provides a method for controlling what reports and providers the Long Term Report series produced for the quarterly cycle generation.

The *LTC Provider Select* Window is accessed using the mouse by clicking **LTC Select Providers (50 file)** on the SUR Main Menu or **Alt** plus **5** on the keyboard.

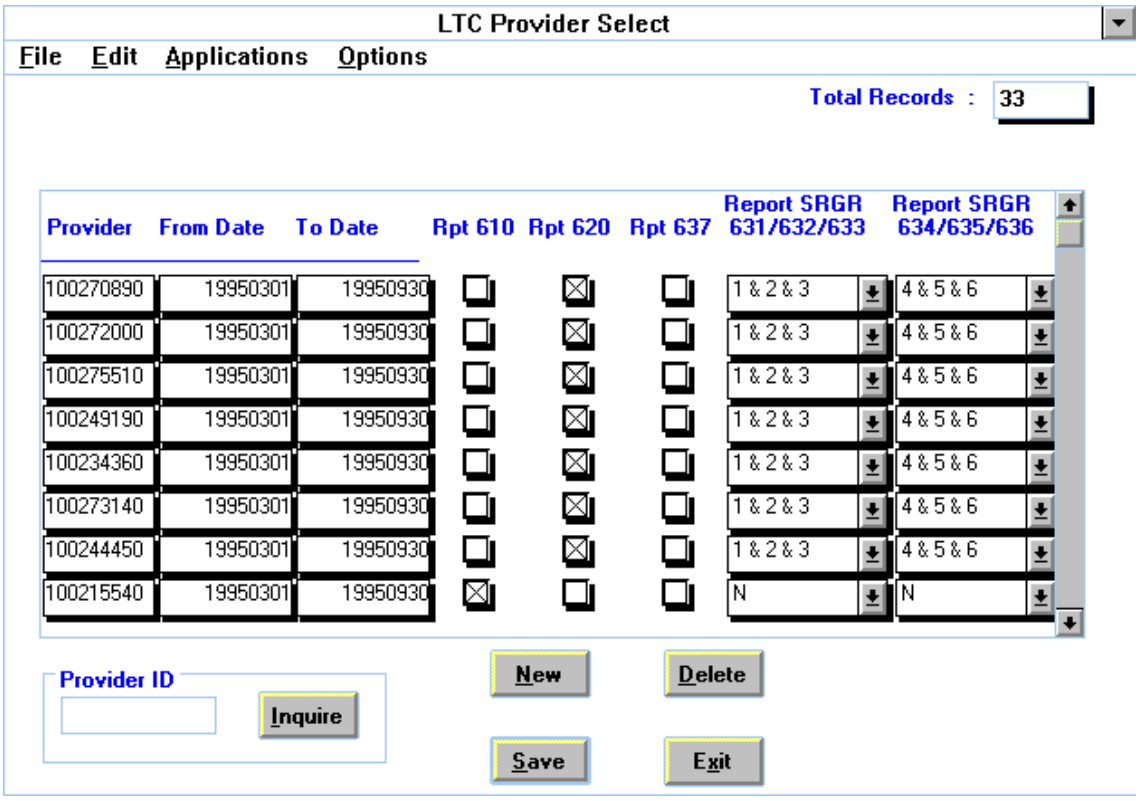


Figure 14.1 – LTC Provider Select Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Inquire
Save	Paste	Cross Reference (20 File)	Sort
Delete	Cut	Selected Providers (30 File)	
Print		Summary Profile (40 File)	
Exit		LTC Select Providers (50 File)	
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 14.2 – LTC Provider Select Window Menu Tree

This is the menu bar for the *LTC Provider Select* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Allows the user to add a new record

Save – Saves changes made to window

Delete – Deletes a selected record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Allows the user to retrieve the records currently on file

Sort – Sorts the records on file

Field Information

Field Name: Total Records

Description – Total number of records that are carried on the file

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Provider

Description – Provider ID number for which LTC reports are being selected

Format – Nine numeric characters

Features – None

Edit – Should be 9 characters

To Correct – Verify typing and enter valid nine digit, numeric provider number

Field Name: From Date

Description – Low date in a range of dates for which the LTC reports selected will be produced

Format – CCYYMMDD

Features – None

Edit – 91001, Invalid date (CCYYMMDD)!

To Correct – Enter date in CCYYMMDD format

Edit – 5048, Date cannot be future date!

To Correct – Enter date = or < present date in CCYYMMDD format

Field Name: To Date

Description – High date in a range of dates for which the LTC reports selected will be produced

Format – CCYYMMDD

Features – None

Edit – 91001, Invalid date (CCYYMMDD)!

To Correct – Enter date in CCYYMMDD format

Edit – From Date > To Date

To Correct – Enter valid date range where from < to

Field Name: Rpt 610

Description – An **X** in this field indicates that a LTC Provider Report is selected for the provider

Format – X

Features – Click to mark **X**

Edit – None

To Correct – n/a

Field Name: Rpt 620

Description – An **X** in this field indicates that a LTC Summary Report is selected for the provider

Format – X

Features – Click to mark **X**

Edit – None

To Correct – n/a

Field Name: Rpt 637

Description – An **X** in this field indicates that a LTC Summary Detail Inpatient Report is selected for the provider

Format – X

Features – Click to mark **X**

Edit – None

To Correct – n/a

Field Name: Report SRGR 631/632/633

Description – None, one, two, three or any combination of the three reports listed in the drop-down list box is selected for the provider.

Format – Three numeric combinations of 1, 2, and 3. For example, 1&2, 1&3, 2&3, 1&2&3, or None

Features – Drop-down list box

Edit – None

To Correct – n/a

Field Name: Report SRGR 634/635/636

Description – None, one, two, three or any combination of the three reports listed in the drop-down list box is selected for the provider.

Format – Three numerical combinations. For example, 4, 5, 6, 4&5, 4&6, 5&6, 4&5&6, or None

Features – Drop-down list box

Edit – None

To Correct – n/a

Field Name: Inquire Provider ID and Button

Description – A provider number is entered in the Inquire Provider ID field and located in the file when **Inquire** is clicked. All records on file are displayed when **Inquire** is clicked and the Provider ID field is left blank.

Format – Nine numeric characters

Features – Systematic location of inquire key

Edit – 91011, Record not found please try again.

To Correct – Verify typing and re-enter provider number, select another provider on which to inquire, or delete the entry

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

Sort order is required – Sort button

System Information

PBL – SUR01.PBL

Window – W_SUR_LTC_PRSELECT

Menu – M_SUR_OPTIONS

Data Windows – DW_LTCPROV_SELECT

System Features

Click **New** to create a new record at the end.

Click **Save** to save changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete of entries from the window. **Delete** allows for multiple simultaneous deletions. To delete one or more entries, the user should double-click the appropriate entry that highlights the entry. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the SUR Main Menu.

Click **Inquire** to inquire on one specific provider or by leaving the provider number blank all providers are displayed.

Section 15: SUR Recipient Summary Select Window

Introduction

The *SUR Recipient Summary Select* window is used to identify the members for whom a selected summary profile is automatically produced.

This window is accessed by clicking the **Selected Recipient (60 file)** on the SUR Main Menu or by pressing **Alt** plus **6** on the keyboard.

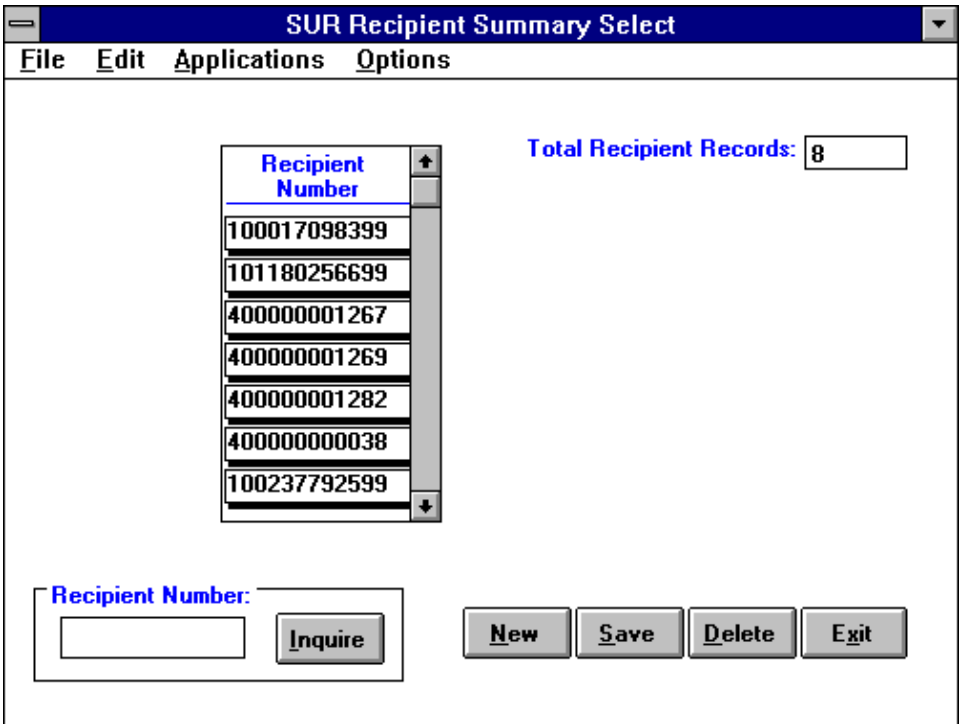


Figure 15.1 – SUR Member Summary Select Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Inquire
Save	Paste	Cross Reference (20 File)	Sort
Delete	Cut	Selected Providers (30 File)	
Print		Summary Profile (40 File)	
Exit		LTC Select Providers (50 File)	
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 15.2 – SUR Member Summary Select Window Menu Tree

This is the menu bar for the *SUR Member Summary Select* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Save – Saves changes made to the window

Delete – Deletes a record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Click to display the records currently on file

Sort – Click to sort the records currently on file

Field Information

Field Name: Recipient Number

Description – Member's Medicaid identification number. Entry of a member number into the Member Number field indicates that a Selected Member Summary Profile Report is requested for the member.

Format – 12 numeric characters

Features – None

Edit – 91019, Member already exists

To Correct – The member number typed is a duplicate. Verify the correct member number was typed. If the correct number was typed, delete the duplicate.

Edit – 80029, Member number must be 12 characters.

To Correct – Verify typing and enter valid 12 numeric member number

Edit – 80032, Invalid Member.

To Correct – Verify typing and enter valid 12 numeric member number

Field Name: Total Recipient Records

Description – Total number of records that are carried on the file

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SELECT_RECP

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_SELECT_RECP

System Features

Click **New** to add members.

Click **Save** to save any changes in the window including new entries, changes, and deletions after the last save. The system confirms that a save was successful with the message *Save Successful*. If the information can not be saved, the system prompts with the message *Save Unsuccessful*. All errors must be corrected before the save successful message appears.

Click **Delete** to delete the input row where the cursor rests. The system prompts with the message *Do you really want to delete this record?* before the deletion occurs. The user should respond accordingly. The system then confirms the delete with the message *Delete Successful* or *Delete Unsuccessful*.

Click **Exit** to close the current window and return to the SUR Main Menu.

Click **Inquire** to enter a member number and locate a specific member in the table. If no member number is entered and **Inquire** is clicked, all members currently in the table appear. If the specific member is not found, an error message informs that the member number is not on the table.

Section 16: SUR Provider Deselection Window

Introduction

The *SUR Provider Deselection* window provides a method for eliminating previously targeted providers from exception processing and rank reporting that allows new cases to surface. The Medicaid provider number of those individuals to be deselected are entered on the *SUR Provider Deselection* window prior to quarterly cycle generation.

This window is accessed by clicking **Provider Deselect (70 file)** on the SUR Main Menu or by pressing **Alt** plus **7** on the keyboard.

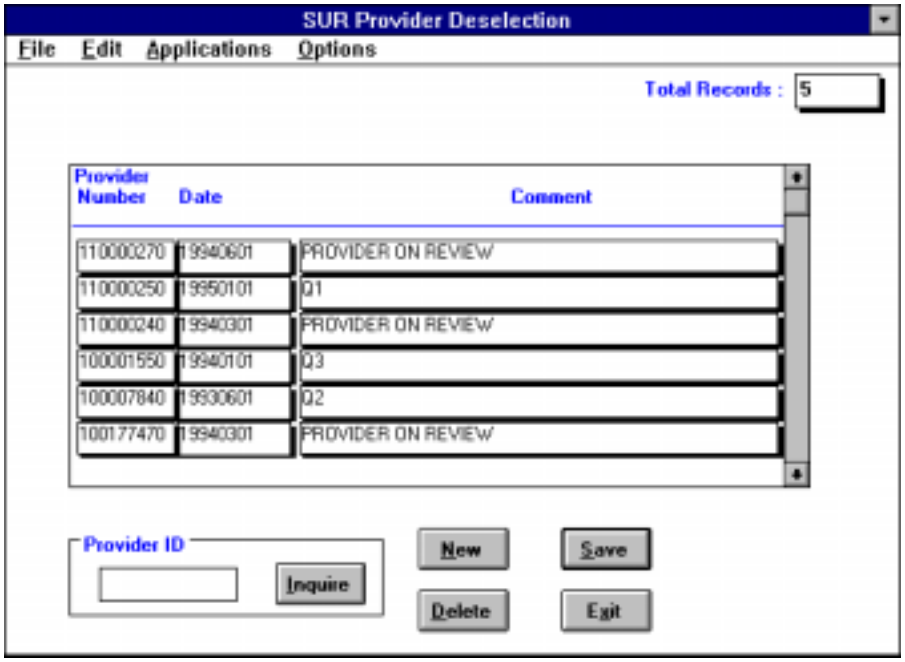


Figure 16.1 – SUR Provider Deselection Window

File	Edit	Application	Options
New	Copy	Option List (10 File)	Inquire
Save	Paste	Cross Reference (20 File)	Sort
Delete	Cut	Selected Providers (30 File)	
Print		Summary Profile (40 File)	
Exit		LTC Select Providers (50 File)	
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 16.2 – SUR Provider Deselection Window Menu Tree

This is the menu bar for the *SUR Provider Deselection* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Save – Saves changes made to the window

Delete – Deletes a selected record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Allows the user to retrieve the records currently on file

Sort – Sorts the records on file

Field Information

Field Name: Total Records

Description – Total number of records that are carried on the file

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Provider Number

Description – Medicaid identification number of the provider

Format – Nine numeric characters

Features – None

Edit – Should be nine characters

To Correct – Verify typing and enter valid nine numeric provider number

Field Name: Date

Description – Field that is used to enter the date of deselection, or other reference date, as specified by the user

Format – Eight numeric characters (CCYYMMDD, or blank)

Features – None

Edit – DataWindow Error, Item 'X' does not pass the validation test (where 'X' = the value typed).

To Correct – Enter date in CCYYMMDD format

Field Name: Comment

Description – Free form field used to enter any additional comments regarding the entry

Format – Alphanumeric characters

Features – None

Edit – None

To Correct – n/a

Field Name: Inquire Provider ID and Button

Description – Provider number is entered in the Inquire Provider ID field and located in the file when **Inquire** is clicked. All records on file are displayed when **Inquire** is clicked and the Provider ID field is left blank.

Format – Nine numeric characters

Features – Systematic location of inquire key

Edit – 80031, Provider not found.

To Correct – Verify typing and re-enter provider number, select another provider to inquire, or delete the entry.

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

Sort order is required – Sort button

System Information

PBL – SUR01.PBL

Window – W_SUR_PROV_DSELECT

Menu – M_SUR_OPTIONS

Data Windows – DW_PROVIDER_DESELECT

System Features

Click **New** to create a new record at the end.

Click **Save** to save changes to the window including new entries and updates. The system prompts with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete entries from the deselected window. **Delete** allows for multiple simultaneous deletions. To delete one or more entries, double-click on the appropriate entry to highlight the entry. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the SUR Main Menu.

Click **Inquire** to inquire on one specific provider or, by leaving the provider number blank all providers are displayed.

Section 17: SUR Recipient Deselection Window

Introduction

The Member Deselection Control file provides a method for eliminating previously targeted member from exception processing and rank reporting that allows new cases to surface. The Medicaid member number of those individuals to be deselected are entered on the *SUR Member Deselection* window prior to quarterly cycle generation.

The *SUR Recipient Deselection* window is accessed by clicking **Recipient Deselect (70 file)** on the SUR Main Menu or using the keyboard by pressing **Alt** plus **R**.

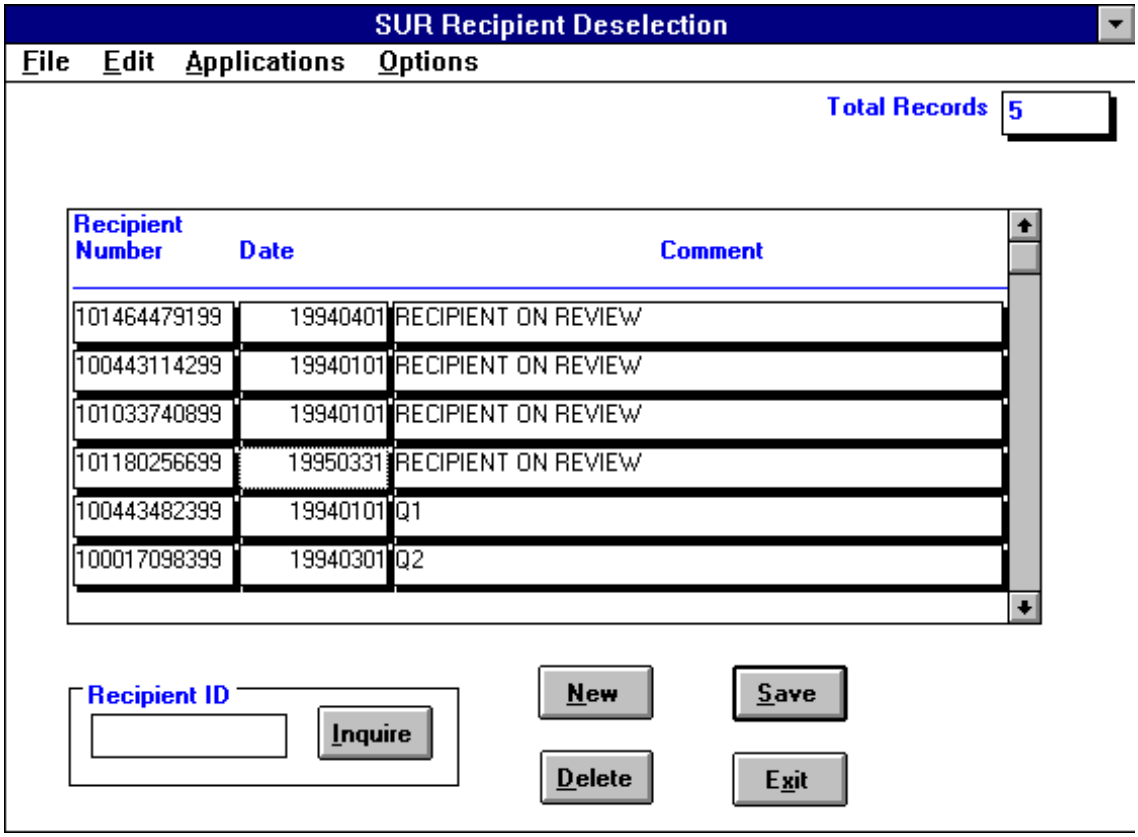


Figure 17.1 – SUR Recipient Deselection Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Inquire
Save	Paste	Cross Reference (20 File)	Sort
Delete	Cut	Selected Providers (30 File)	
Print		Summary Profile (40 File)	
Exit		LTC Select Providers (50 File)	
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 17.2 – SUR Recipient Deselection Window Menu Tree

This is the menu bar for the *SUR Recipient Deselection* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Save – Saves changes made to window

Delete – Deletes a selected record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Allows the user to retrieve the records currently on file.

Sort – Sorts the records on file.

Field Information

Field Name: Total Records

Description – Total number of records displayed on the window

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Recipient Number

Description – Identification number of the member

Format – 12 numeric characters

Features – None

Edit – 80041, Member Not Found.

To Correct – Member number typed is not on the member table. Verify typing and enter valid 12 numeric member number.

Field Name: Date

Description – Field that is used to enter the date of deselection, or other reference date, as specified by the user.

Format – Eight numeric characters (CCYYMMDD, or blank)

Features – None

Edit – 91001, Invalid date (CCYYMMDD)

To Correct – Enter date in CCYYMMDD format.

Field Name: Comment

Description – Free form field that is used to enter any additional comments regarding the entry

Format – Alphanumeric

Features – None

Edit – None

To Correct – n/a

Field Name: Inquire Recipient ID and Button

Description – Member number is entered in the Inquire Member ID field and located in the file when **Inquire** is clicked. All records on file are displayed when **Inquire** is clicked and the Member ID field is left blank.

Format – 12 numeric characters

Features – Systematic location of inquire key

Edit – 60042, Invalid Member Medicaid ID.

To Correct – Verify typing and enter valid 12 numeric member number

Edit – 80041, Member Not Found

To Correct – Member number typed is not on the member table. Verify typing and enter valid 12 numeric member number.

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

Sort order is required – Sort button

System Information

PBL – SUR01.PBL

Window – W_SUR_RECP_DSELECT

Menu – M_SUR_OPTIONS

Data Windows – DW_MEMBER_DSELECT

System Features

Click **New** to create a new record at the end.

Click **Save** to save changes to the window including new entries and updates. The system prompts with the message *Save Successful* or *Save Unsuccessful*.

Click **Delete** to delete of entries from the deselected window. **Delete** allows for multiple simultaneous deletions. To delete one or more entries, double-click on the appropriate entry which highlights the entry. **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the SUR Main Menu.

Click **Inquire** to inquire on one specific member or by leaving the member identification number blank all members are displayed.

Section 18: Provider Select Window

Introduction

The *Provider Select* window presents a listing of provider history/random sample requests, tabled for display on the *Claims Listing* window, or waiting to be processed.

The Provider Select window accesses the following functions:

- Views a listing of tabled requests
- Changes an unprocessed request
- Deletes a claim listing from the table
- Sorts the provider history/sample requests listing
- Accesses the *SUR Provider History/Sample Request* window
- Accesses the *Statistical Summary for Sample Request* window
- Accesses the *SUR Claim Listing* window
- Accesses the *Select Criteria Inquiry* window

This window accessed by clicking **Provider History/Sample** on the SUR Main Menu or using the keyboard, by pressing **H**.

Figure 18.1 – Provider Select Window

File	Applications	Options
New	Option List (10 File)	Inquire
Delete	Cross Reference (20 File)	Statistical Summary
Print	Selected Providers (30 File)	Claim Listing
Exit	Summary Profile (40 File)	Criteria Inquiry
Exit Indiana*AIM*	LTC Select Providers (50 File)	
	Selected Providers (60 File)	
	Provider Deselect (70 File)	
	Member Deselect (70 File)	
	Provider History/Sample	
	Recipient History/Sample	

Figure 18.2 – Provider Select Window Menu Tree

This is the menu bar for the *Provider Select* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Delete – Deletes a selected record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members.

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Click to access the SUR Provider History/Sample Request window for the selected record

Statistical Summary – Click to access the Statistical Summary for Sample Request window for the selected record

Claim Listing – Click to access the SUR Claim Listing window for the selected record

Criteria Inquiry – Click to acces the *Select Criteria* window for the selected record

Field Information

Field Name: Provider Number

Description – Provider's Medicaid ID number for the request logged on the *SUR Provider History/Sample Request* window

Format – Nine numeric characters

Features – Display only

Edit – None

To Correct – n/a

Field Name: Request Date

Description – Date the request was logged on the *SUR Provider History/Sample Request* window

Format – Eight numeric characters (CCYYMMDD)

Features – Display only

Edit – None

To Correct – n/a

Field Name: Request Time

Description – Time the request was logged on the *SUR Provider History/Sample Request* window

Format – Six numeric characters (HHMMSS)

Features – Display only

Edit – None

To Correct – n/a

Field Name: Rqst By

Description – ID of the user who requested the history/sample

Format – Four alphanumeric characters

Features – Display only

Edit – None

To Correct – n/a

Field Name: Purge Date

Description – Seven calendar days from the original request date, or seven calendar days from the last STORE logged for the claim listing

Format – Eight numeric characters (CCYYMMDD)

Features – Display only

Edit – None

To Correct – n/a

Field Name: Srt Opt (1-5)

Description – Sort options applied to the request.

Format – Valid values include the following:

- B—Admit Date
- C—Age
- D—Attending Physician
- E—Category of Service
- F—Claim Charge
- G—Claim Paid
- H—Detail Charge
- I—Detail Allowed
- J—Diagnosis Code
- K—Dispense Date
- L—Date of Payment
- M—Date of Service
- N—DRG
- O—Drug Class
- P—Drug Code
- Q—EOB
- R—ICN
- T—Nursing Home Indicator
- U—Prescribing Physician
- V—Procedure/Modifier Code
- X—Referring Physician
- Y—Revenue Code
- Z—RID

Features – Display only

Edit – None

To Correct – n/a

Field Name: Dat Typ

Description – Date type used for the request

Format – DOP—remittance date, DOS—service date

Features – Display only

Edit – None

To Correct – n/a

Field Name: History Dates [From]

Description – Low date in a range of dates specified for the request

Format – Eight numeric characters (CCYYMMDD)

Features – Display only

Edit – None

To Correct – n/a

Field Name: History Dates [To]

Description – High date in a range of dates specified for the request

Format – Eight numeric characters (CCYYMMDD)

Features – Display only

Edit – None

To Correct – n/a

Field Name: Rnd Sel

Description – Random percentage type used for generation of the request; percent of claims or percent of members

Format – C or R

Features – Display only

Edit – None

To Correct – n/a

Field Name: Pct Rnd

Description – Sample percentage requested

Format – Three numeric characters

Features – Display only

Edit – None

To Correct – n/a

Other Messages/Edits

You have to select a row – Inquire and Change buttons

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_PROV_SEL_NEW

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_PROV_SEL_NEW

System Features

Click **New** to access to the *SUR Provider History/Sample Request* window where a new request is logged.

Click **Change** to access to an unprocessed request where changes is applied. Access the change function is denied once the request has been processed.

Click **Delete** to delete selected claim listings from the table. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Exit** to return to the SUR Main Menu.

Click **Inquire** to access to the *SUR Provider History/ Sample Request* window for the request selected.

Section 19: SUR Provider History/Sample Request Window

Introduction

The *SUR Provider History/Sample Request* window creates a representation of the provider's overall practice by displaying a percentage of randomly generated claim examples (a sample percentage of 100 percent would generate a total history). The accompanying *Statistical Summary for History/Sample Request* window is intended to assist in deciding on the appropriate percentage, based on the statistical universe, to produce a statistically valid random sample. Frequently, a provider's misutilization involves only two or three areas; numerous select and sort options can be used to focus on only those areas identified as problems.

Logged requests are processed for display on the *SUR Claim Listing* window.

The *SUR Provider History/Sample Request* window accesses the following functions:

- Requests a provider history or random sample claim listing.
- Accesses the *Statistical Summary for Sample Request* window for the provider displayed.
- Accesses the *SUR Claim Listing* window for the corresponding processed request.

This window is accessed by clicking **New** or **Change** on the *Provider Select* window. It can also be accessed by using the keyboard and pressing **Alt** plus **N**. This window is also accessed for previously logged requests, by highlighting the desired request and clicking **Inquire**, or selecting **Inquire** from the Options menu.

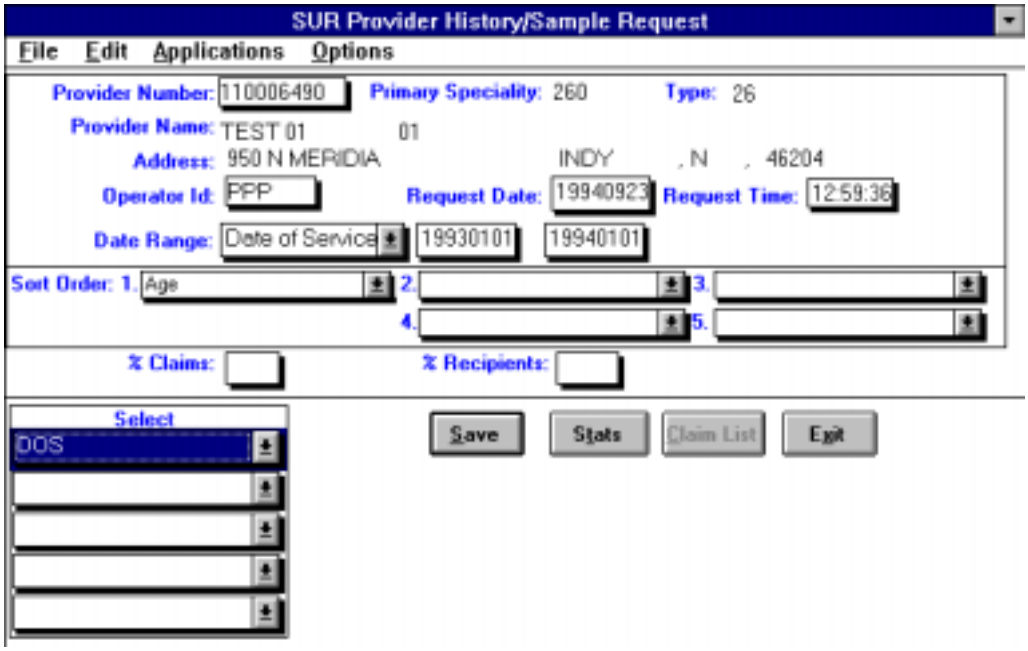


Figure 19.1 – SUR Provider History/Sample Request Window

File	Applications	Options
New	Option List (10 File)	Statistical Summary
Save	Cross Reference (20 File)	Claim Listing
Delete	Selected Providers (30 File)	
Print	Summary Profile (40 File)	
Exit	LTC Select Providers (50 File)	
Exit Indiana*AIM*	Selected Member (60 File)	
	Provdier Deselect (70 File)	
	Member Deselect (70 File)	
	Provider History/Sample	
	Recipient History/Sample	

Figure 19.2 – SUR Provider History/Sample Request Window Menu Tree

This is the menu bar for the *SUR Provider History/Sample Request* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Save – Saves changes made to window

Delete – Deletes a selected record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

Exit Indiana*AIM* – Exits Indiana*AIM*

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Statistical Summary – Click to access the Statistical Summary for *Sample Request* window for the provider referenced

Claim Listing – Click to access the *SUR Claim Listing* window for the corresponding request

Field Information

Field Name: Provider Number

Description – Provider's Medicaid ID number

Format – Nine numeric characters

Features – None

Edit – 80031, Provider Not Found.

To Correct – Verify and type a valid nine-digit provider number

Field Name: Primary Specialty

Description – Specialty designated as primary by the provider as carried on the Provider table

Format – Three numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Type

Description – Provider type as carried on the Provider table

Format – Two numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Provider Name

Description – Provider's name in Last, First format

Format – Alphanumeric (Last, First, M.I.)

Features – System generated

Edit – None

To Correct – n/a

Field Name: Address

Description – Physical address of the provider number designated as primary by the provider, as carried on the Provider table

Format – Street, city, two alphabetic character state code, seven numeric character ZIP code

Features – System generated

Edit – None

To Correct – n/a

Field Name: Operator Id

Description – Clerk identification code of the user requesting information

Format – Four alphanumeric characters

Features – None

Edit – DataWindow Error, Value required for this item.

To Correct – Type a Operator ID

Field Name: Request Date

Description – Current date

Format – Eight numeric characters (CCYY/MM/DD)

Features – System generated on access

Edit – None

To Correct – n/a

Field Name: Request Time

Description – Current time

Format – Six numeric characters (HH:MM:SS)

Features – System generated on access

Edit – None

To Correct – n/a

Field Name: Date Range (Type)

Description – Date type to be used for sample generation

Format – Date of service Paid Date

Features – Drop-down box

Edit – DataWindow Error.

To Correct – Select a Date Range type

Field Name: Date Range (From)

Description – Low date in a range of dates to be used for report generation

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91040, Invalid Date - must be CCYYMMDD.

To Correct – Enter valid date in CCYYMMDD format

Field Name: Date Range (To)

Description – High date in a range of dates to be used for report generation

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edit – 91040, Invalid Date - must be CCYYMMDD

To Correct – Enter valid date in CCYYMMDD format

Field Name: Sort Order (1-5)

Description – Click **Sort Order** to display a drop-down box containing sort value options for sample generation. Click on the value to populate field with option tag name.

Format – Valid values include the following:

- Admit Date
- Age
- Attending Physician
- Category of Service

- Claim Charge
- Claim Paid
- Detail Charge
- Detail Allowed
- Diagnosis Code
- Dispense Date
- DOP
- DOS
- DRG
- Drug Class
- Drug Code
- EOB
- ICN
- Lock-In Indicator
- Nursing Home Code
- Prescribing Physician
- Procedure/Modifier Code
- Member Name
- Referring Physician
- Revenue Code
- RID

Features – Clicking on listed value populates the Sort Order field with the option tag name

Edit – None

To Correct – n/a

Field Name: % Claims

Description – Sample percentage requested, based on claim volume

Format – Three numeric characters

Features – Either % CLAIMS or % MEMBERS is required for sample generation

Edit – 91098, Must be Numeric.

To Correct – Enter a numeric percentage value

Edit – 91006, Field is Required.

To Correct – Enter either a % claims or % members

Field Name: % Recipients

Description – Sample percentage requested, based on member volume

Format – Three numeric characters

Features – Either % CLAIMS or % MEMBERS is required for sample generation

Edit – 91098, Must be Numeric.

To Correct – Enter a numeric percentage value

Edit – 91006, Field is Required.

To Correct – Enter either a % claims or % members

Field Name: Select (Option)

Description – Click **Select** to display a drop-down box containing select values available for active claim types. Click on value to populate Select field with option tag name. The *Selection Criteria* window automatically displays for value entry. Up to five select options is used for sample generation.

Format – Valid values include the following:

- Admit Date
- Age
- Attending Physician
- Category of Service
- Claim Charge
- Claim Paid
- Detail Charge
- Detail Allowed
- Diagnosis Code
- Dispense Date
- DOP
- DOS
- DRG
- Drug Class
- Drug Code
- EOB
- ICN
- Lock-in Indicator
- Nursing Home Code
- Prescribing Physician

- Procedure/Modifier Code
- Referring Physician
- Revenue Code
- RID

Features – Click on listed value to populate the Select (option) field with the option tag name and access the *Selection Criteria* window

Edit – None

To Correct – n/a

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_PROV_HIST_SAMPLE_NEW

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_PROV_HIST

DW_SUR_PROV_HIST_SELECT

System Features

Click **Save** to log the request for processing. The system prompts with the message *Save Successful* or *Save Unsuccessful*.

Click **Stats** to gain access to the *Statistical Summary for Sample Request* window.

Click **Exit** to return to the *Provider Select* window

Click **Claim List** to access the *SUR Claim Listing* window for processed requests. For unprocessed requests, the Claim List button is inactive.

Section 20: Selection Criteria Window

Introduction

The *Selection Criteria* window is a popup window consequent to Select Criteria tag name specification on the *SUR Provider History/Sample Request* window. The *Selection Criteria* window is used to specify sample selection criteria values for the selection criteria tag specified on the *SUR Provider History/Sample Request* window. The *Selection Crit*eria window allows up to 10 rows for criteria selection.

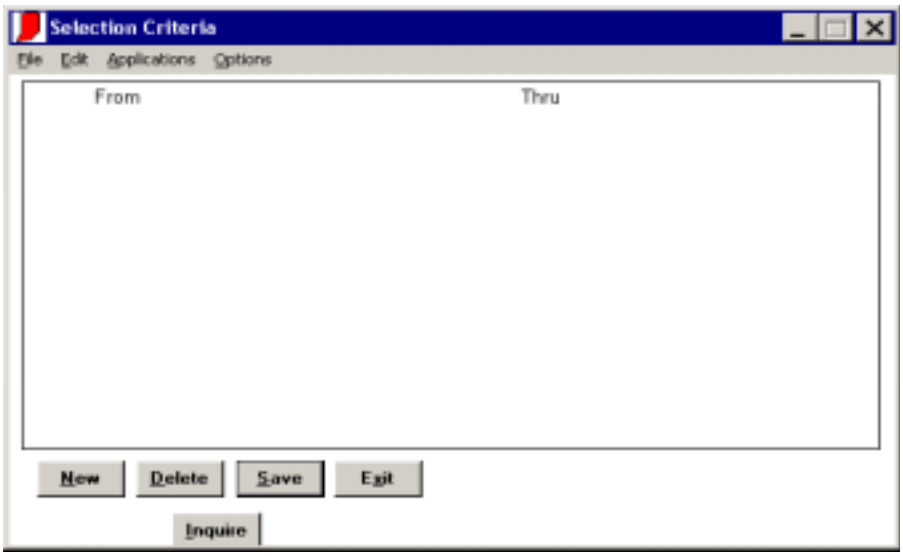


Figure 20.1 – Selection Criteria Window

File	Edit	Applications	Options
New	Copy	Option List (10 File)	Inquire
Save	Paste	Cross Reference (20 File)	
Delete	Cut	Selected Providers (30 File)	
Print		Summary Profile (40 File)	
Exit		LTC Select Providers (50 File)	
Exit Indiana*AIM*		Selected Member (60 File)	
		Provider Deselect (70 File)	
		Member Deselect (70 File)	
		Provider History/Sample	
		Recipient History/Sample	

Figure 20.2 – Selection Criteria Window Menu Tree

This is the menu bar for the *Selection Criteria* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Save – Saves changes made to window

Delete – Deletes a selected record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Edit

This menu selection allows adjustments to the data entered.

Copy – Copies text to another area or application

Paste – Pastes, cuts, or copies text from another area

Cut – Deletes text and places it on the clipboard

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Click to access the selection criteria records on file for the request

Field Information

Field Name: Select Value (From)

Description – Low value in a range of values to be selected for the select option tag name displayed. Up to 19 "From" values are defined per option tag. Clicking **New** allows entry of more than one value for the tag.

Table 20.1 – (Select value) From Field Format

Option Tag Name	Value Format
Admit Date	CCYYMMDD
Age	999
Attending Physician	999999999X
Category of Service	99
Claim Paid	9999999.99
Detail Charge	9999999.99
Detail Paid	9999999.99
Diagnosis Code	X9999
Dispense Date	CCYYMMDD
DOP	CCYYMMDD
DOS	CCYYMMDD
DRG	999
Drug Class	9999
Drug Code	99999999999
EOB	999
ICN	
9999999999999	
Lock-in Indicator	Y or N
Nursing Home Code	Y or N
Prescribing Physician	999999999X
Procedure/Modifier Code	XXXXXXXXXXXXXXXXXX
Referring Physician	999999999X
Revenue Code	999
RID	999999999999

Features – None

Edit – Editing depends on select option chosen.

To Correct – Type a valid 'FROM value' format for the select option chosen.

Field Name: Select Value (Thru)

Description – High value in a range of values to be selected for the select option displayed. Up to 19 "Thru" values are defined per option tag. A Thru value must be selected if a From value is typed.

Table 20.2 – (Select value) Thru Field Format

Option Tag Name	Value Format
Admit Date	CCYYMMDD
Age	999
Attending Physician	999999999X
Category of Service	99
Claim Paid	9999999.99
Detail Charge	9999999.99
Detail Paid	9999999.99
Diagnosis Code	X9999
Dispense Date	CCYYMMDD
DOP	CCYYMMDD
DOS	CCYYMMDD
DRG	999
Drug Class	9999
Drug Code	99999999999
EOB	999
ICN	9999999999999
Lock-in Indicator	Y or N
Nursing Home Code	Y or N
Prescribing Physician	999999999X
Procedure/Modifier Code	XXXXXXXXXXXXXXXXXX
Referring Physician	999999999X
Revenue Code	999
RID	999999999999

Features – None

Edit – Editing depends on select option chosen

To Correct – Type a valid 'THRU value' format for the select option chosen.

Other Messages/Edits

Format Needs to Be XXXXXXXXXXXXXXXXXX – Format for procedure is incorrect

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_SELECT_CRIT

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_SELECT_CRIT

System Features

Click **New** to create a new record at the end.

Click **Delete** to delete entries from the window. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?*. The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful* appears.

Click **Save** to save changes to the window including new entries and updates. The user is prompted with the message *Save Successful* or *Save Unsuccessful*.

Click **Exit** to return to the *SUR Provider History/Sample Request* window.

Click **Inquire** to access to the *Select Criteria Inquiry* window where all criteria logged for the request are displayed.

Section 21: Select Criteria Inquiry Window

Introduction

The *Select Criteria Inquiry* window displays all selection criteria with corresponding values that have been logged for the request.

This window is accessed by clicking **Inquire** on the *Selection Criteria* window. It is also accessed on the keyboard by pressing **Alt** plus **I**.

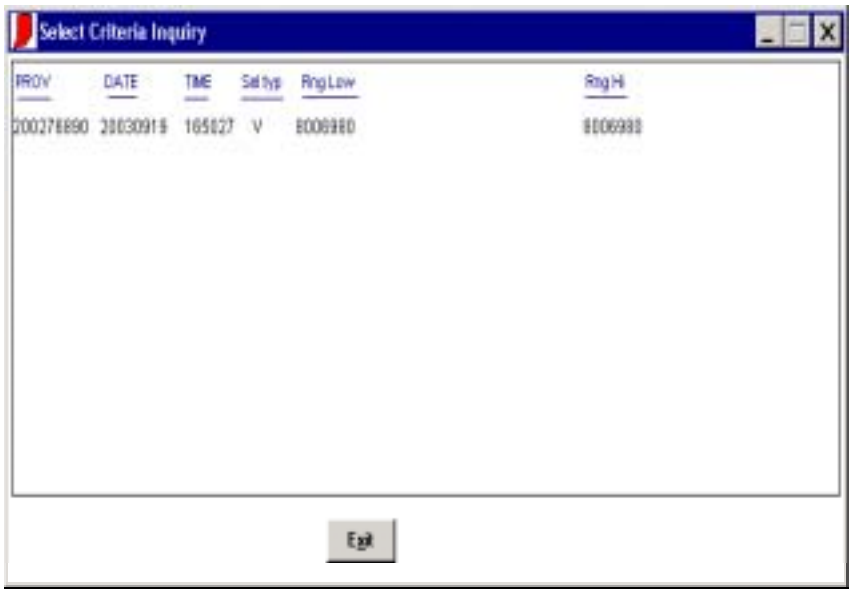


Figure 21.1 – Select Criteria Inquiry Window

Field Information

Field Name: PROV

Description – Provider number requested for history/sample

Format – Nine numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: DATE

Description – Date of the request

Format – Eight numeric characters (CCYYMMDD)

Features – System generated

Edit – None

To Correct – n/a

Field Name: TIME

Description – Time of the request

Format – Six numeric characters (HHMMSS)

Features – System generated

Edit – None

To Correct – n/a

Field Name: Select type

Description – Selection type code assigned by the system that corresponds to the selection type entered

Format – One alphabetic character

Features – System generated

Edit – None

To Correct – n/a

Field Name: Rng Low

Description – Low value in a range of values entered for the selection type

Format – Dependent upon select type

Features – System generated

Edit – None

To Correct – n/a

Field Name: Rng Hi

Description – High value in a range of values entered for the selection type

Format – Dependent upon select type

Features – System generated

Edit – None

To Correct – n/a

Other Messages/Edits

None

System Information

PBL – SUR01.PBL

Window – W_SUR_PROV_SEL_CRIT_INQ

Menu – M_SUR_OPTIONS

Data Windows – DW_PROV_SEL_CRIT_INQ

System Features

Click **Exit** to return to the *Selection Criteria* window.

Section 22: SUR Claim Listing Window

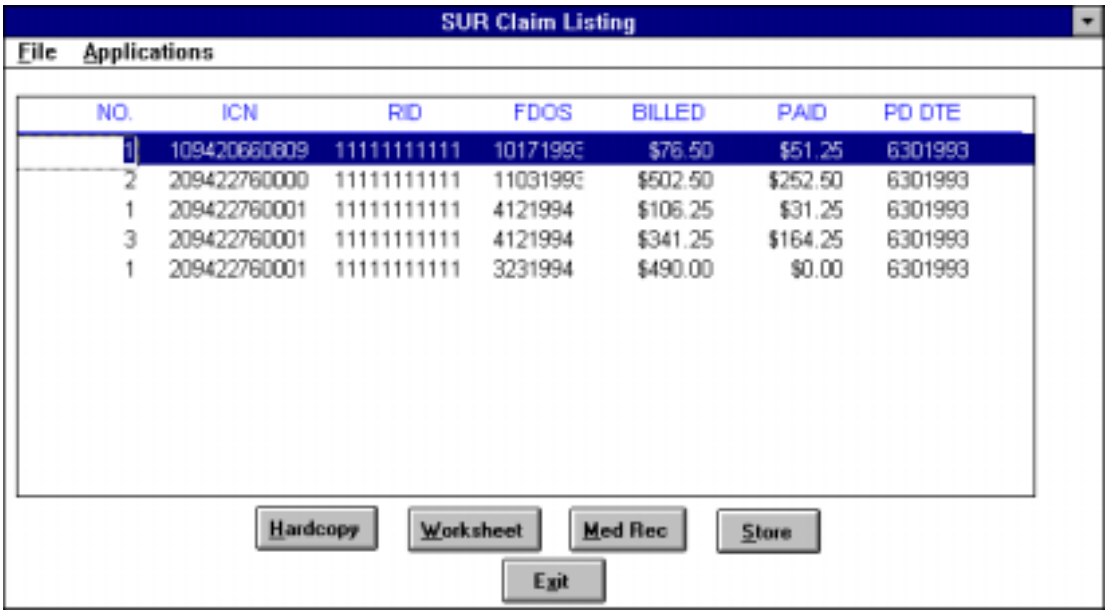
Introduction

The *SUR Claim Listing* window presents a listing of the selected claims that meet the criteria of the corresponding request on the *Provider History/Sample Request* window. The claims are identified by ICN. Displayed claim information includes RID, from date of service, billed and paid amounts, and the paid date.

Claim listings remain online for seven calendar days, at which time they automatically purge from the file. Four function buttons are available to further process the data as described in the following field definitions. Options such as report hardcopy, worksheet, and medical record request generation are possible through use of the function buttons.

The *SUR Claim Listing* window is accessed by clicking **Claim List** on the *SUR Provider History/Sample Request* window. Keyboard access is available from *the SUR Provider History/Sample Request* window by pressing **Alt** plus **C**. Access is also available from the Option menu bar on the *Provider Select* and *SUR Provider History/Sample Request* windows.

Figure 22.1 – SUR Claim Listing Window



File	Applications	Options
Print	Option List (10 File)	Stat. Summary
Exit	Cross Reference (20 File)	
Exit Indiana*AIM*	Selected Providers (30 File)	
	Summary Profile (40 File)	
	LTC Select Providers (50 File)	
	Selected Member (60 File)	
	Provider Deselect (70 File)	
	Member Deselect (70 File)	
	Provider History/Sample	
	Recipient History/Sample	

Figure 22.2 – SUR Claim Listing Window Menu Tree

This is the menu bar for the *SUR Claim Listing* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

Print – Prints a data window, current window or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Member (60 File) – Click to access the SURS Selected Member Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control File for providers

Member Deselect (70 File) – Click to access the SURS Deselection Control File for members.

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample - Click to access the SURS Recipient History/Random Sample request function.story request functions.

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Stat. Summary – Click to access the *Statistical Summary for Sample Request* window for the provider referenced

Field Information

Field Name: Provider

Description – Provider's Medicaid ID number for the referenced provider history / sample request

Format – Nine numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Request Date

Description – Date that the referenced provider history / sample request was entered

Format – Eight numeric characters (CCYYMMDD)

Features – System generated

Edit – None

To Correct – n/a

Field Name: Request Time

Description – Time that the referenced provider history/sample request was entered

Format – Six numeric characters (HHMMSS)

Features – System generated

Edit – None

To Correct – n/a

Field Name: NO.

Description – Claim listing sequence number

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: ICN

Description – Internal control number of each claim listed

Format – 12 numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: RID

Description – Member Medicaid identification number for each claim listed

Format – 12 numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: FDOS

Description – Date of the first detail carried on file for each claim listed

Format – Eight numeric characters (MM/DD/CCYY)

Features – System generated

Edit – None

To Correct – n/a

Field Name: BILLED

Description – Billed amount of each claim listed

Format – Nine numeric character

Features – System generated

Edit – None

To Correct – n/a

Field Name: PAID

Description – Paid amount of each claim listed

Format – Nine numeric character.

Features – System generated

Edit – None

To Correct – n/a

Field Name: PD DTE

Description – Remittance date of each claim listed

Format – Eight numeric characters (MM/DD/CCYY)

Features – System generated

Edit – None

To Correct – n/a

Other Messages/Edits

None

System Information

PBL – SUR01.PBL

Window – W_SUR_CLAIM_LIST

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_CLAIM_LIST

System Features

Click **Hardcopy** to submit the sample for production of a hard copy SURS Selected Provider Detail Report for the claims listed. The system responds with message *Hardcopy Indicator Updated*.

Click **Worksheet** to submit the sample for production of a worksheet for each claim listed. The system responds with message *Worksheet Indicator Updated*.

Click **Med Rec** to submit the sample for production of a medical records request form for the claims listed. The system responds with message *Med Rec Indicator Updated*.

Click **Store** to store the sample online for seven additional calendar days from the current date. The system responds with message *Purge Dte Set to New Date* with the new date indicated. If a sample is not "stored" using the Store button, it systematically purges from the file in seven calendar days from the original request date.

Click **Exit** to return to the calling window.

Section 23: Stat. Summary For Sample Request Window

Introduction

The *Stat. Summary For Sample Request* window provides volume information used in determining sample size when requesting histories and samples on the *SUR Provider History/Sample Request* window.

This window is accessed by clicking **Stats** on the *SUR Provider History/Sample Request* window. Keyboard access is available from the *SUR Provider History/Sample Request* window, by pressing **Alt** plus **T**. Access is also available from the Option menu bar on the *Provider Select* and *SUR Provider History/Sample Request* windows.

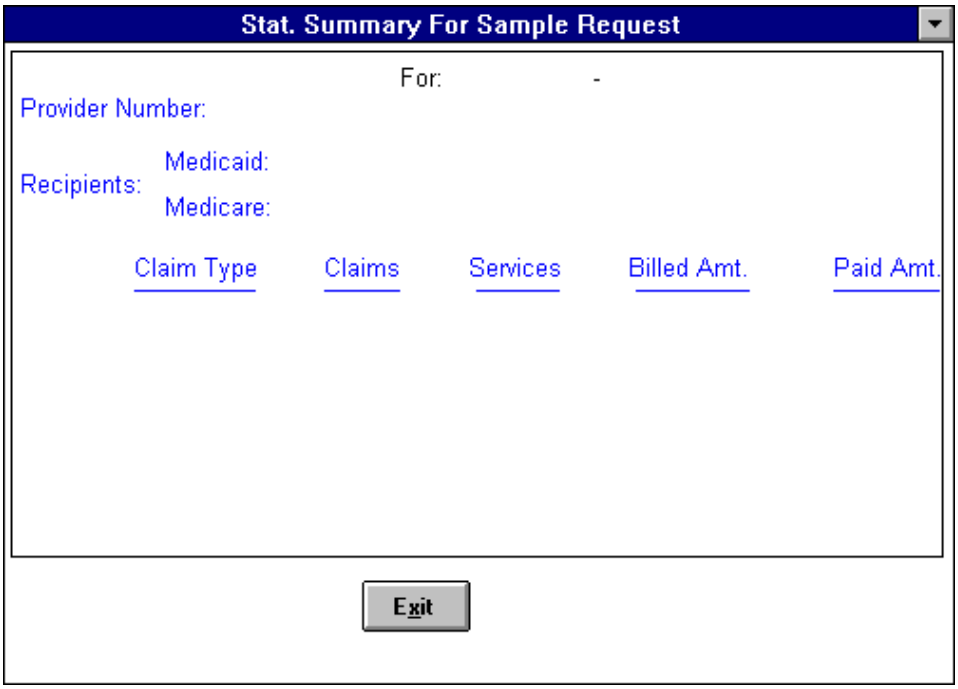


Figure 23.1 – Stat. Summary For Sample Request Window

File
Print
Exit
Exit Indiana*AIM*

Figure 23.2 – Stat. Summary For Sample Request Window Menu Tree

This is the menu bar for the *Stat. Summary For Sample Request* window. The menus are in a single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. Commands or window options that are faded are not available at this time.

A command or window option is selected by the following methods:

1. Click the command or window option title.
2. Click the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Field Information

Field Name: For

Description – SURS reporting master file date range as carried on the SUR Options Control File ("10-File")

Format – MM/DD/YY - MM/DD/YY

Features – System generated

Edit – None

To Correct – n/a

Field Name: Provider Number

Description – Provider's Medicaid ID number

Format – Nine numeric characters

Features – System plug from calling window

Edit – None

To Correct – n/a

Field Name: Recipients - Medicaid

Description – The unduplicated number of Medicaid members with Medicaid services billed by the referenced provider during the reporting period

Format – Five numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Recipients - Medicare

Description – Unduplicated number of Medicaid members with Medicare services billed by the referenced provider during the reporting period

Format – Five numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Claim Type

Description – Claim type code for the claims submitted by the referenced provider during the reporting period

Format – One alphabetic character

Edit – None

To Correct – n/a

Field Name: Claims

Description – Number of claims submitted by the referenced provider for each of the claim types the provider has billed during the reporting period

Format – Four numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Services

Description – Number of services billed by the referenced provider for each of the claim types listed during the reporting period

Format – Six numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Billed Amt.

Description – Amount billed by the referenced provider for each of the claim types listed during the reporting period

Format – Nine numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: Paid Amt.

Description – Amount paid to the referenced provider for each of the claim types listed during the reporting period

Format – Nine numeric characters

Features – System generated

Edit – None

To Correct – n/a

Field Name: TOTAL: (Claims, Services, Billed $. Paid $)

Description – Total number of claims, services, amounts billed and paid for all claim types for the referenced provider during the reporting period.

Format – Same as individual fields

Features – System generated

Edit – None

To Correct – n/a

Other Messages/Edits

None

System Information

PBL – SUR01.PBL

Window – W_SUR_STAT_SUM

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_STAT_SUM

System Features

Click **Exit** to return to the calling window.

Section 24: Recipient Select Window

Introduction

The *Recipient Select* window presents a listing of recipient history/random sample requests processed or waiting to be processed.

The *Recipient Select* window accesses the following functions:

- Views a listing of tabled requests
- Changes an unprocessed request
- Deletes a claim listing from the table
- Accesses the *SUR Recipient History/Sample Request* window
- Accesses the *Select Sort Order* window
- Accesses the *Select Criteria Inquiry* window

The *Recipient Select* window is accessed by clicking **Recipient History/Sample** button on the SUR Main Menu. The window is also accessed from the SUR Main Menu using the keyboard, by pressing **S**.

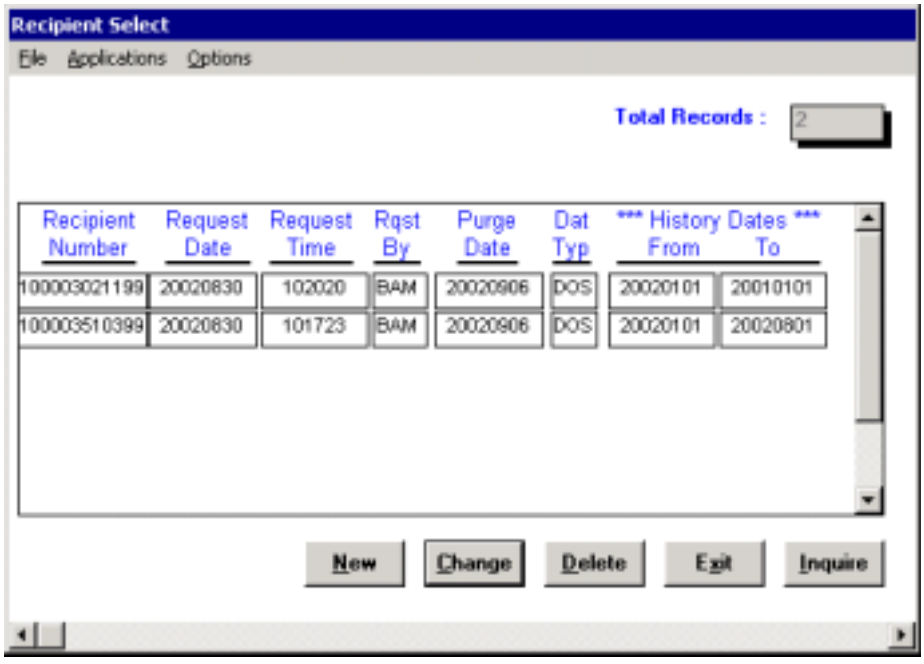


Figure 24.1 – Provider Select Window

File	Applications	Options
New	Option List (10 File)	Inquire
Delete	Cross Reference (20 File)	Sort
Print	Selected Providers (30 File)	
Exit	Summary Profile (40 File)	
Exit Indiana*AIM*	LTC Select Providers (50 File)	
	Selected Providers (60 File)	
	Provider Deselect (70 File)	
	Recipient Deselect (70 File)	
	Provider History/Sample	
	Recipient History/Sample	

Figure 24.2 – Recipient Select Window Menu Tree

This is the menu bar for the *Provider Select* window. The menus are in single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. If a command or window option is faded, the command or window option is not available at this time.

A command or window option is selected by the following methods:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Delete – Deletes a selected record

Print – Prints a data window, current window or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR Subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Recipient (60 File) – Click to access the SURS Selected Recipient Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control file for providers

Recipient Deselect (70 File) – Click to access the SURS Deselection Control file for recipients

Provider History/Sample – Click to access the SURS Provider History/Random Sample Request function

Recipient History/Sample – Click to access the SURS Recipient History/Random Sample Request function

Menu Selection: Options

This menu selection accesses windows that relate to the control file.

Inquire – Click to access the SUR Recipient History/Sample Request window for the selected record

Sort – Allows the user to apply up to four sorts on the recipient select records. Valid values include the following:

- Recipient
- Request Date
- Requestor ID
- Purge Date
- History From Date

Field Information

Field Name: Recipient Number

Description – Recipient's Medicaid ID number for the request logged on the *SUR Recipient History Request* window

Format – 12 numeric characters

Features – Display only

Edits – None

To Correct – n/a

Field Name: Request Date

Description – Date the request was logged on the *SUR Recipient History Request* window

Format – CCYYMMDD

Features – Display only

Edits – None

To Correct – n/a

Field Name: Request Time

Description – Time the request was logged on the *SUR Recipient History Request* window

Format – HHMMSS

Features – Display only

Edits – None

To Correct – n/a

Field Name: Rqst By

Description – ID of the user who requested the history

Format – Three alphanumeric characters

Features – Display only

Edits – None

To Correct – n/a

Field Name: Purge Date

Description – Seven calendar days from the original request date

Format – CCYYMMDD

Features – Display only

Edits – None

To Correct – n/a

Field Name: Dat Typ

Description – Date type used for the request

Format – DOP—remittance date, DOS—service date

Features – Display only

Edit – None

To Correct – n/a

Field Name: History Dates [From]

Description – Low date in a range of dates specified for the request

Format – CCYYMMDD

Features – Display only

Edit – None

To Correct – n/a

Field Name: History Dates [To]

Description – High date in a range of dates specified for the request

Format – CCYYMMDD

Features – Display only

Edit – None

To Correct – n/a

Other Messages/Edits

You have to select a row – Inquire and Change buttons

Save successful – Save button

Save unsuccessful – Save button

Do you really want to delete this record? – Delete button

Delete successful – Delete button

Delete unsuccessful – Delete button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_RECP_SEL_NEW

Menu – M_SUR_OPTIONS_DATES

Data Windows – DW_SUR_RECP_SEL_NEW

System Features

Click **New** to access the *SUR Recipient History/Sample Request* window where a new request is logged.

Click **Change** to access an unprocessed request where changes are applied. Access the change function is denied once the request has been processed.

Click **Delete** to delete selected claim listings from the table. When **Delete** is clicked, the system prompts with the message *Do you really want to delete this record?* The user should respond accordingly. A confirmation message of *Delete Successful* or *Delete Unsuccessful*. appears.

Click **Exit** to return to the SUR main menu.

Click **Inquire** to access the *SUR Recipient History/ Sample Request* window for the request selected.

Section 25: SUR Recipient History Request Window

Introduction

The *SUR Recipient History/Sample Request* window provides the capability to create a representation of the recipient's overall paid claim history by displaying date-specific generated claim examples.

Logged requests are processed for display on the *SUR Claim Listing* window.

The *SUR Recipient History/Sample Request* window is used to request a recipient history. This window is accessed by clicking **New** or **Change** on the *Recipient Select* window. The window is also accessed from the *Recipient Select* window by pressing **Alt** plus **N** on the keyboard. The *SUR Recipient History/Sample Request* window is also accessed for previously logged requests, by highlighting the desired request and clicking **Inquire**, or selecting **Inquire** from the Options menu.

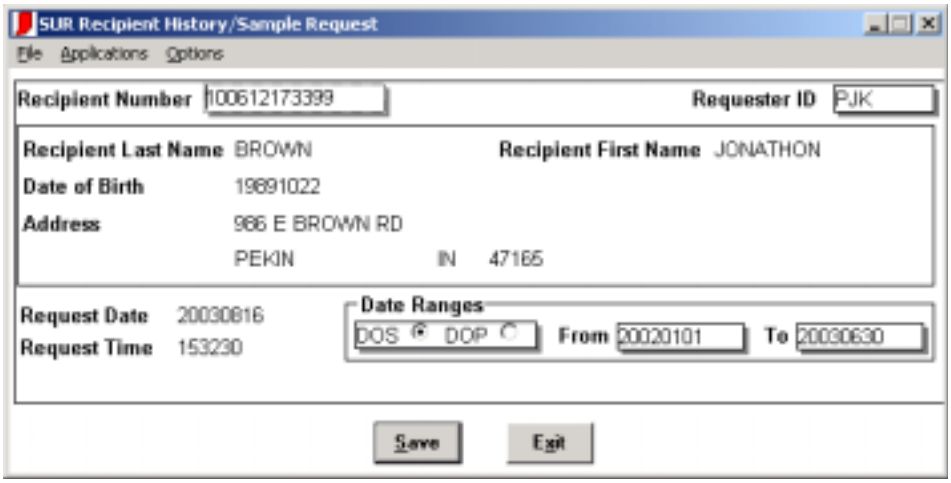


Figure 25.1 – SUR Recipient History Request Window

File	Applications
New	Option List (10 File)
Save	Cross Reference (20 File)
Delete	Selected Providers (30 File)
Print	Summary Profile (40 File)
Exit	LTC Select Providers (50 File)
Exit Indiana*AIM*	Selected Recipient (60 File)
	Provider Deselect (70 File)
	Recipient Deselect (70 File)
	Provider History/Sample
	Recipient History/Sample

Figure 25.2 – SUR Recipient History Request Window Menu Tree

This is the menu bar for the *SUR Recipient History/Sample Request* window. The menus are in single line boxes. The menu titles on this illustration reflect the overall menu commands and window options.

Menu Bar

The menu bar is below the window title bar and contains the headings for the list of commands or window options.

The list of available commands or window options displays in a drop-down box. If a command or window option is faded, the command or window option is not available at this time.

A command or window option is selected by the following methods:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box displays. Click the command or press **Alt** plus the underscored letter of the command.

Menu Selection: File

This command provides the following options:

New – Adds a new record

Save – Saves changes made to window

Delete – Deletes a selected record

Print – Prints a data window, current window, or the entire screen

Exit – Exits the window

*Exit Indiana*AIM – Exits Indiana*AIM*

Menu Selection: Applications

These menu options access the following areas in the Indiana*AIM* SUR subsystem.

Options List (10 File) – Click to access the SURS Options Control file

Cross Reference (20 File) – Click to access the SURS Cross-Reference Control file

Selected Providers (30 File) – Click to access the SURS Selected Provider Reporting Control file

Summary Profile (40 File) – Click to access the SURS Summary Profile Reporting Control file

LTC Select Providers (50 File) – Click to access the SURS LTC Reporting Control file

Selected Recipient (60 File) – Click to access the SURS Selected Recipient Reporting Control file

Provider Deselect (70 File) – Click to access the SURS Deselection Control file for providers

Recipient Deselect (70 File) – Click to access the SURS Deselection Control file for recipients

Provider History/Sample – Click to access the SURS Recipient History/Random Sample Request function

Recipient History/Sample – Click to access the SURS Recipient History/Random Sample Request function

Field Information

Field Name: Recipient Number

Description – Recipient's Medicaid ID number

Format – 12 numeric characters

Features – None

Edit – 80041, Recipient Not Found

To Correct – Verify and type a valid 12-digit recipient number

Field Name: Requester ID

Description – ID of the user who requested the history

Format – Three alphanumeric characters

Features – Display only

Edit – None

To Correct – n/a

Field Name: Recipient Last Name

Description – Recipient's last name

Format – Alphanumeric

Features – System generated

Edit – None

To Correct – n/a

Field Name: Recipient First Name

Description – Recipient's first name

Format – Alphanumeric

Features – System generated

Edit – None

To Correct – n/a

Field Name: Date of Birth

Description – Recipient’s date of birth

Format – CCYYMMDD

Features – System generated

Edit – None

To Correct – n/a

Field Name: Address

Description – Recipient’s address

Format – Street, city, two alphabetic character state code, seven numeric character ZIP code

Features – System generated

Edit – None

To Correct – n/a

Field Name: Request Date

Description – Current date

Format – CCYYMMDD

Features – System generated on access

Edit – None

To Correct – n/a

Field Name: Request Time

Description – Current time

Format – HHMMSS

Features – System generated on access

Edit – None

To Correct – n/a

Field Name: Date Range (Type)

Description – Date type to be used for sample generation

Format – Date of Service or Paid Date

Features – Radio button

Edit – n/a

Field Name: Date Range (From)

Description – Low date in a range of dates to be used for report generation

Format – CCYYMMDD

Features – None

Edit – 91040, Invalid Date - must be CCYYMMDD.

To Correct – Enter valid date in CCYYMMDD format

Field Name: Date Range (To)

Description – High date in a range of dates to be used for report generation

Format – CCYYMMDD

Features – None

Edit – 91040, Invalid Date - must be CCYYMMDD.

To Correct – Enter valid date in CCYYMMDD format

Other Messages/Edits

Save successful – Save button

Save unsuccessful – Save button

Continue without saving? – Exit button

System Information

PBL – SUR01.PBL

Window – W_SUR_RECP_HIST_SAMPLE_NEW

Menu – M_SUR_OPTIONS

Data Windows – DW_SUR_RECP_HIST

System Features

Click **Save** to log the request for processing. The system prompts with the message *Save Successful* or *Save Unsuccessful*.

Click **Exit** to return to the *Provider Select* window.

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

1115(a) Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by CMS. See also *Health Care Financing Administration, Waiver*.

11971 State form 11971; see *8A*.

1261A Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*

1500 This is a claim form used by participating Indiana Health Coverage Programs (IHCP*)* providers to bill medical and medically related services. See also *CMS-1500*.

1902(a)(1) Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness*.

1902(a)(10) Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.

1902(a)(23) Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*

1902(r)(2) Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.

1903(m) Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts.*

1915(a) Section of the Social Security Act that states requirements for Medicaid.

1915(b) Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.
1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission
450B	Certification by Physician for Long Term Care Services.
590 Program	A State health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
7748	State Form 7748, Medicaid Financial Report
8A	*DPW Form 8A (State Form 11971), Notice to Provider of Member Deductible*. Used to relay member spenddown information to providers when the date of service is the same as the spenddown met date.
AA	Anesthesia Assistant.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAC	Alternative or Augmentative Communication device.
AAP	American Academy of Pediatrics.
AAS	Atomic absorption spectrophotometer.
ABA	American Banking Association.
ABG	Arterial blood gas.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.

ACOG	American College of Obstetricians and Gynecologists.
ACS	Affiliated Computer Services. State Healthcare PBM. Pharmacy Benefits Manager, Drug Rebate Services.
ACSW	Academy of Certified Social Workers.
ADA	American Dental Association.
ADAP	AIDS Drug Assistance Program.
ADC	Adult day care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.
ADL	Activities of daily living.
Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children is replaced by Temporary Assistance to Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance members, who are 65 years old or older, or members under any other category who are entitled to benefits under Medicare.
AHF	Antihemophiliac factor.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act. Replaced by Temporary Assistance to Needy Families (TANF).
Aid to the Blind (AB)	A classification or category of members eligible for benefits under the IHCP.
AIDS	Acquired Immune Deficiency Syndrome.
AIM	Advanced Information Management.
ALJ	Administrative Law Judge.

allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ALS	Advanced life support.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARC	Association of Retarded Citizens.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
Attending Physician	The physician providing specialized or general medical care to a member.
Auditing Contractor	The entity under contract with the Office of Medicaid Policy and Planning (OMPP) to conduct audits of long-term-care facilities or other functions and activities as designated by OMPP.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.

AVR	Automated voice-response system used by providers to verify member eligibility by phone.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	A statement of charges for medical services, the submitted claim document, or electronic record; which may contain one or more services performed.
billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider that prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
BLS	Basic Life Support.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.
Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
BQAMIS	Bureau of Quality Assurance Management Information System.
BSN	Bachelor of Science in Nursing.

BSW	Bachelor of Social Work.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of IHCP services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits and procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal; a document from the Indiana State Department of Health (ISDH).
C519	Authorization for Member Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
CARF	Commission on Accreditation of Rehabilitation Facilities
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)
case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).

CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider that submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CCSW	Certified Clinical Social Worker.
CDC	Centers for Disease Control.
CDFC	County Division of Family and Children.
CDPW	County Department of Public Welfare, which is changed to the County Offices of the Division of Family and Children.
CDT	Current Dental Terminology.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees and family members of military retirees, now known as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).
Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CHIP	Children's Health Insurance Program.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.

claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for IHCP claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP.
Cm	Centimeter.
CMHC	Community Mental Health Center.
CMI	Case Mix Index.
CMN	Certificate of Medical Necessity.
CMS	Centers for Medicare and Medicaid Services.
CMS-1500	CMS-approved standardized claim form used to bill professional services. Formerly referred to as HCFA-1500.
COB	Coordination of benefits.
co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after the deductible has been met. The co-insurance or a percentage amount is paid by IHCP if the member is eligible for Medicaid. See also *Cost Sharing*.
Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.

concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contractor	Offeror with whom the State successfully negotiated a contract pursuant to *IC 12-1-7-17*. **Auditing Contractor** – The entity under contract with the OMPP to conduct audits of long-term-care facilities or other functions and activities as designated by the OMPP. **Fiscal Agent Contractor** – The offeror(s) with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities. **Rate-Setting Contractor** – Entities under contract with the OMPP to perform rate-setting activities for hospitals and long-term-care facilities.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
copayment or copay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services.*
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.
cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.

county office	County offices of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members subject to the limitations of the *Indiana Administrative Code* (IAC).
CP	Clinical psychologist.
CPAS	Claims processing assessment system. An automated claims analysis tool used by the State for contractor quality control reviews.
CPM	Continuous Passive Motion.
CPS	Child Protective Services.
CPT	Current Procedural Terminology.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central Processing Unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRLD	Computer report to laser disk.
CRNA	Certified Registered Nurse Anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to IHCP benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.

CSW	Certified Social Worker
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
CVP	Central venous pressure.
D&E	Diagnostic and evaluation (in reference to services and providers).
DASS	Delivery and Support System.
data element	A specific unit of information having a unique meaning.
DC	Doctor of Chiropractic.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
DDE	Direct data entry.
DDS	Doctor of Dental Surgery.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug Efficacy Study and Implementation, drug determined to be less than effective (LTE); not covered by the IHCP.
designee	A duly authorized representative of a person holding a superior position.
detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition.*
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through CMS.
DHS	Department of Human Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.

direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.
disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DMHA	Division of Mental Health and Addictions.
DO	Doctor of Osteopathy.
DOB	Date of birth.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Family and Social Services Administration
DPW Form 8A	See *8A.*
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the IHCP.
Drug Efficacy Study and Implementation (DESI)	A drug determined to be less than effective (LTE) and not covered by the IHCP.
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series number is usually associated with the acronym.
DSS	Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.

duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
E/M	Evaluation and Management.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; most commonly, long-term care (LTC); or nursing home (NH), or nursing facility (NF).
ECM	Electronic claims management; overall management of claim transmittal via electronic media; related to ECS, EMC, ECC, and paperless claims.
ECS	Electronic claims submission. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EDS	Electronic Data Systems Corporation, the IHCP claims processing and third party liability contractor.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EIP	Early Intervention Program
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible member	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EMS	Emergency medical services.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.

EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members. See also *MRN*.
EOP	Explanation of payment, term previously used by the IHCP for the claim summary statement – currently know as a remittance advice (RA). Other insurers continue to use the term for claim statements to providers.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible members younger than 21 years old offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End Stage Renal Disease.
EST	Eastern Standard Time, which is also Indianapolis local time, is a constant in *the majority* of the state of Indiana. This means that from the last Sunday in April to the last Sunday in October Indianapolis is on the same time as the states observing Central Standard Time (CST), like Chicago. From the last Sunday in October to the last Sunday in April Indianapolis is on the same time as the states observing Eastern Standard Time (EST), like New York. This is because Indiana does not observe daylight savings time.
EVS	Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.

FDB	First DataBank.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FFS	Fee-for-service.
FID	Federal Investigation Database.
field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
Fiscal Agent Contractor	The offeror with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities.
fiscal month	Monthly time interval in a fiscal year.
Fiscal Year	The designated annual reporting period for an entity: State of Indiana – July 1 through June 30 Federal – October 1 through September 30
FISS	Fiscal intermediary shared system.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility.*
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.

FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
FTE	Full time employee.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
GCN*SEQND	Generic code sequence number classification system.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.
Gm	Gram.
GPCI	Geographic practice cost index.
GPCPD	Governor's Planning Council for People with Disabilities.
GPI	Generic pricing indicator.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as "paper" and "manual".
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.

HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel, Inc. The IHCP prior authorization, surveillance and utilization review and medical policy contractor
HCFA-1500	CMS-approved standardized claim form used to bill professional services. Now referred to as CMS-1500.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	Healthcare Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana's preventive care program for IHCP members younger than 21 years old. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.
HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC	Health insurance carrier number.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPAA	Health Insurance Portability and Accountability Act

HIPP	Health insurance premium payments.
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*
Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.
Hoosier Healthwise	Hoosier Healthwise is an IHCP managed care program that consists of two components including Primary Care Case Management (PCCM) and risk-based managed care (RBMC).
HOPA	Hospital outpatient area.
HPB	Health Professions Bureau.
HPSA	Health professional shortage area.
HPSB	Health Professions Service Bureau.
HRI	Health-related items.
HRR	High risk register (in relation to audiological screening).
HSA	Home service agency.
HSPP	Health services provider in psychology.

IAC	*Indiana Administrative Code – Indiana rules.* State government agency administrative procedures.
IC	Indiana Code – Indiana laws.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICHIA	Indiana Comprehensive Health Insurance Association, a health insuring organization for special situations.
ICLPPP	Indiana Childhood Lead Poisoning Prevention Program.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEMS	Indiana Emergency Medical Service.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IHCP	Indiana Health Coverage Program.
IMCA	Indiana Motor Carrier Authority.
IMCS	Indiana Motor Carrier Services.

IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana Family and Social Service Administration (IFSSA)	The State agency responsible for the coordination and administration of social service programs in the state of Indiana. The OMPP, under Indiana Family and Social Security Administration (IFSSA), is the single State agency responsible for the administration of the IHCP.
Indiana State Department of Health (ISDH)	The State agency responsible for promotion of health; providing guidance on public health issues; ensuring the quality of health facilities and programs and the administration of certain health programs. The Bureau of Family Health Services is the bureau within the Indiana State Department of Health (ISDH) organization charged with the administration of the Children's Special Health Care Services Division (CSHCS) as well as the Maternal and Child Health Division (MCH) and the Division of Women, Infants, and Children (WIC).
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.

IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPAS	Indiana Pre-Admission Screening.
IPP	Individualized Program Plan..
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health; currently known as the Indiana State Department of Health.
ISDH	Indiana State Department of Health; previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
L	Liter.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
LCN	Letter control number.
LCSW	Licensed Clinical Social Worker.
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.

LMFT	Licensed Marriage and Family Therapist.
LMHC	Licensed Mental Health Counselor.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed Practical Nurse.
LSL	Lower specification limit, pertains to quality control charts.
LSW	Licensed Social Worker.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to members.
LTE	Less than effective drugs.
M/M	Medicare/Medicaid.
MAC	Maximum allowable cost for drugs as specified by the federal government.
MAC	Monitored anesthesia care
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
Managed Care PCCM	*Members in the primary care case management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.*
Managed Care RBMC	*In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.*

mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	A pilot program that was available in Marion county from January 1997 through December 1999. It was a voluntary risk-based managed care program for IHCP enrollees that were considered disabled or chronically ill according to the State's established criteria.
MCS	Managed Care Solutions (now called Lifemark Corporation).
MD	Medical Doctor.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency*.
Medicaid Select	A managed care program for the aged, blind and disabled population consisting of a Primary Care Case Management (PCCM) delivery system.
Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. Members in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.

medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A or Part B for services authorized by Medicare Part A or Part B.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Member*.
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual member.
member restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted members.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.*

mental retardation	Significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
MHS	Managed Health Services.
MI	Mental illness.
MI/DD	Mental illness and developmental disability.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral.
misutilization	Any usage of the IHCP by any of its providers or members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
Ml	Milliliter.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
MMRT	Medicaid Medical Review Team.
MOC	Memorandum of Collaboration; a Hoosier Healthwise document that provides a formal description of the terms of collaboration between the primary medical provider (PMP) and the preventive health care service provider (PHCSP). It also serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MR/DD	Mental retardation and developmentally disabled.

MRN	Medicare Remittance Notice. A form provided by Indiana*AIM* and sent to members. The MRN details the payment or denial of claims submitted by providers for services provided to members.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team, unit which makes decision regarding Disability Determination.
MS	Mail stop.
MSN	Master of Science in Nursing.
MSS	Master of Social Sciences.
MSW	Master of Social Work.
MWU	Medicaid Waiver Unit, the IDDARS unit which manages the HCBS Waiver Programs.
NAS	Non-ambulatory service.
NASW	National Association of Social Workers.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NDDF	National Drug Data File.
NEC	Not elsewhere classified.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility; also seen as ECF, NH, and LTC.
NH	Nursing home; also seen as ECF, NF, and LTC.
NIH	National Institutes of Health.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.

non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act.
OBRA-90	Omnibus Budget Reconciliation Act of 1990.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.
OD	Doctor of Optometry.
OFC	Office of Family and Children.
OIG	Office of the Inspector General.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter, in reference to drugs.
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs IHCP functions under the direction of the single state agency. The single state agency may perform all IHCP functions itself or it may delegate certain functions to other processing agencies.

outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a IHCP member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a IHCP member resulting from the failure of the contractor to use available information or to process correctly.
override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.
PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by the IHCP.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by IHCP that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.

Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary.*
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In.*
participant	One who participates in the IHCP as either a provider or a member of services.
participating members	Individuals who receive Title XIX services during a specified period of time.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve IHCP members and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PAS Form 4B	Pre-Admission Screening Notice of Assessment Determination form.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PC	Personal computer.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Members in the Primary Care Case Management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
PCN	Primary care network.
PCP	Primary Care Provider.

PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
PEN	Parenteral and enteral nutrition .
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device which enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PET	Positron Emission Tomography.
PGA	Peer group average.
PHC	Primary home care. IHCP-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHCSP	Preventive health care services provider; a provider of well-child care, pre-natal care services, or care coordination services.
PHO	Physician hospital organization.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.
physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
PKU	Phenylketonuria.

Plan of Care	A formal plan developed to address the specific needs of an individual. It links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMF	Provider master file.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO).*
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
Premium	Due from member in order to be eligible for Package C.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.

prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
Prior Authorization or Prior Review and Approval	The procedure for the office's prior review and authorization, modification, or denial of payment for covered medical services and supplies within IHCP allowable charges. It is based on medical reasonableness, necessity, and other criteria as described in the *IAC Covered Services Rule* and *Medical Policy Rule* found in the *Appendix* to this manual.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that is enrolled as a provider of services and provides a covered IHCP service to an IHCP member.
Provider Agreement	A contract between a provider and the OMPP setting out the terms and conditions of a provider's participation in the IHCP. It must be signed by the provider prior to any reimbursement for providing covered services to members.
provider enrollment application	Required document for all providers who provide services to IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.

provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor or dentist.
PSRO	Professional standards review organization.
purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
Rate-Setting Contractor	An entity under contract with the OMPP to perform rate-setting activities.
RBA	Room and Board Assistance.
RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.

RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by the OMPP.
reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reimbursement	Payment made to a provider, pursuant to Federal and State law, as compensation for providing covered services to members.
reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.
rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.

repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Retrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic
RID	Recipient Identification (ID) number; the unique number assigned to a member who is eligible for IHCP services.
risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool.*
RN	Registered Nurse.
RNC	Registered Nurse Clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment.
RPT	Registered physical therapist.
RPTS	Research Project Tracking System.
RR	Resident review.
RUG	Resource Utilization Group.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
RVU	Relative value unit.
SA/DE	State Authorization/Data Entry.
SBOH	State Board of Health; previous term for the State Department of Health.
SCP	Specialty care physicians.

screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
SED	Seriously emotionally disturbed.
SEH	Seriously emotionally handicapped.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SI/IS	Severity of illness/intensity of services.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Severely mentally ill.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Sixth Omnibus Budget Reconciliation Act.
SOBRA	Omnibus Budget Reconciliation Act of 1986.

SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.
specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
Spend-down	Process whereby IHCP eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor.
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.

State	Spelled as shown, State refers to the state of Indiana and any of its departments or agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.
State Form 11971	See *8A.*
State Form 7748	Medicaid Financial Report, used for cost reporting.
State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the IHCP in Indiana.
State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pended, denied, and so forth.
stop-loss insurance	Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year. See also *Reinsurance*.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
submission	The act of a provider sending billings to EDS for payment.
subsystem	A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.

SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Centers for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements: 1. Statistical analysis 2. Exception processing 3. Provider and member profiles 4. Retrospective detection of claims processing edit and audit failures and errors 5. Retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards 6. Retrospective detection of fraud and abuse by providers or members 7. Sophisticated data and claim analysis including sampling and reporting 8. General access and processing features 9. General reports and output
Survey Agency	The ISDH is the designated survey agency responsible for surveying, monitoring, reviewing, and certifying institutional providers of service who request or agree to participate in the IHCP. The ISDH also certifies several other provider types. These types are discussed under the section titled; *State, County Contractor Responsibilities* included in this chapter.
suspended transaction	A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).
suspense file	Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).
systems analyst or engineer	Responsible for performing the following activities: 10. Detailed system and program design 11. System and program development 12. Maintenance and modification analysis and resolution 13. User needs analysis 14. User training support 15. Development of personal IHCP knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TBI	Traumatic brain injury.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.

therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.
Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirements of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.

TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
TPN	Total Parenteral Nutrition.
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
TRICARE	Formerly known as the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees, and family members of military retirees.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
UM	Utilization management.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization Review. A formal assessment of the medical necessity, efficiency, or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
USPHS	United States Public Health Service.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.

utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VA	Veterans Administration.
VFC	Vaccines for Children program.
VIP	Validation Improvement Plan.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
waiver	Waiver allows members to move from the traditional Medicaid environment to a less restrictive environment. Some of the statutory entitlements are waved for the member.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children younger than five years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.
Y2K	Year 2000. Commonly used in computer system compliance issues.

Index